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Working with Transnational Women from Latin American Countries from a Feminist Therapy Framework: A Guide for Mental Health Providers Working with This Population

Diana Hinojosa
University of Denver

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Running head: TRANSNATIONAL WOMEN AND FEMINIST THERAPY

WORKING WITH TRANSNATIONAL WOMEN FROM LATIN AMERICAN
COUNTRIES FROM A FEMINIST THERAPY FRAMEWORK: A GUIDE FOR
MENTAL HEALTH PROVIDERS WORKING WITH THIS POPULATION

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Diana Hinojosa, M.A.

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APPROVED:

Henrietta Pazos, PsyD, Chair

Shelly Smith-Acuña, PhD, Member

Crosby Troha, PsyD, Member

Abstract

The experiences of transnational families in the United States have largely been examined as they relate to the impact that separation and migration have on the family system. In most recent years, women have assumed the experience of migration and have moved to countries like the United States to work and provide for their families back home. Transnational families are typically understood as family members who live separated from each other, often across national borders, but continue to maintain unity and connections with each other. The following literature review will examine the social factors impacting Latin American women's decision to migrate to the United States and incorporates factors impacting those with documented and undocumented status. This paper will examine the history, theory, and key components of feminist therapy and provide a visual guide and suggestions for mental health providers of how this theory can be applied to the commonly identified needs of this particular population. The following paper will examine the benefits of applying feminist therapy to the experience of transnational women while providing an understanding of how this theoretical framework could be modified and adapted when working with cultural factors of this population. Additionally, this paper will explore the limitations of working with transnational women from a feminist therapy perspective and recommendations for further research and interventions. For the purposes of this paper, the term Latina will be used in an effort to address specific challenges, stereotypes, and beliefs of those in the Latinx community that identify as women.

Note:

It should be noted that although the following paper will examine feminist therapy and its application to transnational Latina women, the goal of this paper is to help mental health providers understand how core concepts of feminist therapy can be modified and used to adapt to the specific needs of specific populations. The strengths of feminist therapy should be noted along with the limitations, particularly as it relates to the application of transnational women from Latin America.

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Transnational Families

Over the years, men have traditionally been known as the financial providers of households in Latin American families. This has been largely due to the gender roles that exist among many countries in Latin America. Even though gender and gender roles are social constructs, cultural and religious beliefs have reinforced the behaviors and attitudes that women and men assume in the home and workforce in Latin America. These roles are described through the terms of *machismo* and *marianismo*. Machismo is typically associated with a strong sense of masculine pride, and marianismo is associated with a feminine passive and “submissive” role (Roger Thayer Stone Center for Latin American Studies, 2017). As a result of these gender roles, men have been expected to become the main providers of their family, while the women have often remained at home and become the primary caretakers of their children. “Because women are expected to be nurturing and morally superior to men, they have been assigned to duties associated with the family, in particular the rearing and education of children” (Roger Thayer Stone Center for Latin American Studies, 2017). Family is highly valued across Latin American cultures, and as such, the role of women as primary caretakers has become tradition.

The assignment of these roles has often left women feeling disempowered and limited in their options to challenge their roles. Violence against women and “femicide” has often been the result of the gender inequality and unequal power of distribution between men and women (Gasman & Alvarez, 2017). Recently, however, women have become active members in the work force and have challenged their roles as primary caretakers. Policy changes and education have provided women with more opportunities

to participate in the work force. “In 1990, only 44 percent of women in Latin America participated in the labor force. In 2014, this ratio increased to 54 percent, close to levels seen in the United States and emerging markets in Asia” (Novta, Werner, & Wong, 2016). This change has also been noticed in the involvement of women in migration. Issues of crime, financial challenges, and political and drug corruption are some of the reasons influencing people’s decision to leave their homes in Latin America, particularly in countries like Mexico (Pew Research Center, 2009). The need to improve quality of life and provide for their families back home has encouraged many families to relocate, often leaving children and other family members behind. In Latin American families, this often includes moving to countries like the United States.

As a result of these gender norms, men have traditionally left their countries and relocated to the United States in order to provide for their families back home. For decades, however, women from Latin America have also become involved in migration, despite gender norms and challenges. The United Nations reported that at a global level, the percentage of female migrants has increased from 47.2 in 1980 to 49.6 in 2005. (Fry, 2006). In the United States, the Pew Hispanic Center analysis of the March 2005 Current Population Survey reported “that of an estimated 11.1 million unauthorized migrants, 58% of the adults were male while 42% were female (Passel, as cited by Fry, 2006). In contrast, females accounted for 52% of the adult legal migrant population in 2005” (Passel, as cited by Fry, 2006). Traditionally, men have assumed more work in areas of construction, landscaping, agriculture and commercial cleaning. Women, however, have assumed more roles in the domestic cleaning or child care industry (Schmalzbauer, 2010).

Transnational Women

The increase in migration of women from Latin America may be due to several factors. Latin American countries highly value family unity and community. The concept of *familismo*, is defined as “a set of normative beliefs espoused by Latino populations that emphasize the centrality of the family unity and stress the obligations and support that family members owe to both nuclear and extended kin” (Sabogal, Marin, Otero-Sabogal, Marin, & Perez-Stable, 1987, as cited in German, Gonzales, & Dumka, 2009). Traditionally, women have fulfilled their commitments to family and community by following the established gender norms, but women have also taken migration as an opportunity not just to help themselves, but as a way to support their families (Pedraza, 1991). “Indeed, Cuban women overwhelmingly saw work as the opportunity to help the family, rather than as an opportunity for self-actualization” (Pedraza, 1991). Additionally, immigrant women have found low-wage job opportunities often not available in their home countries. In the United States, immigrant women have been largely represented in housekeeping and maid jobs. “The largest numbers of immigrant women workers (882,663) were maids and housekeepers in 2015. Approximately 501,740 were in nursing, psychiatric, and home health aides; followed by cashiers (480,391); registered nurses (454,057); and janitors and building cleaners (364,494)” (American Immigration Council, 2017). These job opportunities not only allow women to help and support their families in their home countries, but it allows them to work in jobs that often align with their cultural values and expectations of gender roles. Despite these opportunities, immigrant women are often left with the on-going expectation to remain the primary source of emotional support for the children in their family.

Research conducted by Rhacel Parreñas, (2005) on transnational Filipino/a families suggests that though children may experience emotional disruptions when their father leaves the home, their lives might be more dramatically impacted when their mother leaves. This is due to the cultural and gender expectations that have been placed on women as primary caretakers. It was found that when a mother leaves the home, and migrates to a different country, the fathers did not always assume the caretaking role and responsibility. Rather, other women in the family system, often grandmothers, became the primary caretakers. Women from Honduras identified writing letters, and frequent phone calls as ways in which they attempted to maintain communication and relationships with their family members (Schmalzbauer, 2010).

Migrant women from afar, however, continue to be expected to provide for their families financially and emotionally. While women have faced many of the challenges that men face when migrating to the United States, including issues of border crossing, language barriers, racism and discrimination, financial stressors, and fear of deportation, research of women from Mexico has suggested that separation from families has been the most emotionally challenging stressor for women (Crocker, 2015). “The primary emotions immigrants associated with these separations were loneliness, frustration, and sadness, which sometimes led to longer-term depression” (Crocker, 2015). Participants from this study identified fear, depression, loneliness, sadness, and stress as the most common emotional experiences (Crocker, 2015). It is for these reasons that mental health providers working with migrant women from Latin America need to be aware of the emotional challenges being faced, often as a result of a strong sense of family values, and the expectations of being the primary caretakers at home. Not only might they be

experiencing traumatic emotional challenges that may have developed prior to their migration, but since their migration, they may have developed some or all of the identified mental health concerns, including fear, depression, loneliness, sadness, and stress.

As women and their families face the emotional challenges of being separated from each other, women also have to face the experiences and adjustments of migration and relocation. “Symptoms precipitated or aggravated by the process of migration, such as depression, anxiety, psychosomatic illnesses, addictions, or behavior problems, can appear in any of the family members in any location at any time” (Falicov, 2007). During the immigration experience, women from Central America and Mexico have faced additional challenges including violence and sexual acts. In a 2011 study conducted in the Washington D.C. area, 28 participants from South America, Central America and Mexico, were recruited and interviewed regarding their history, and experiences with trauma and loss. Particularly for women from Central America and Mexico,

“The trips often lasted weeks to months and were marked by violence, deprivation, and fear. Six women described life-threatening situations during their journey, typically involving gangs, thieves, or coyotes. These events typically involved being threatened with a weapon. A few women reported having sexual relations with men who were helping them travel to the United States” (Kaltman, Mendoza, Gonzales, Serrano, & Guarnaccia, 2011).

Although many of the women may have anticipated such experiences during their migration journey, the emotional impact of this may lead to the development of post-traumatic stress disorder symptoms and additional mental health concerns.

While the level of emotional distress experienced by each woman that migrates to the United States may differ, it is necessary for mental health providers in the U.S. to understand the complexity of their lived experiences. As previously noted, a review of the literature suggests that the emotional challenges of being separated from family members, along with the traumatic experiences that may be endured during and after the migration journey, are all factors contributing to immigrant women's overall mental health. "Transnational relational stress is a nearly inevitable, and often transient aspect of the family strains imposed by migration" (Falicov, 2007). For these reasons, it would be helpful for mental health providers to have a framework and understanding of how they can intervene and support this specific population. Feminist therapy, as proposed by Laura S. Brown, Ph.D. can be understood as a "strategy for effecting growth and healing for people in distress" (Brown, 2012). More importantly, feminist therapy can provide mental health providers working with Latina immigrants the knowledge to understand and analyze the impact of oppression, gender, power dynamics, and multicultural identities on mental health. According to Brown, "feminist therapy does not simply study the "other" in order to offer a neutral perspective on that experience. Rather, what is inherent in feminist therapy is the radical notion that silenced voices of marginalized people are considered to be the sources of the greatest wisdom" (Brown, 2012, p.2). Feminist therapy can guide mental health providers with the understanding of the systemic factors impacting the immigrant women's experiences while also addressing the distress caused by the experience of being away from family members, the traumatic experiences lived during and after the migration journey, and the difficulties of challenging gender roles.

Feminist Therapy

History and Theory

Feminist therapy has its roots in humanistic psychotherapy. The theory followed the behavioral movement proposed by Carl Rogers that “a therapist ought to be seeing the person across the room as a prized fellow human rather than a specimen of a particular diagnosis, as well as his emphasis on the quality of relationship between therapist and client” (Brown, 2012, p. 9). The movement was largely influenced by the feminist perspectives of Naomi Weisstein and Phyllis Chesler, and the contributions of Inge K. Broverman, Donald M. Broverman, Frank E. Clarkson, Paul S. Rosenkrantz, and Susan R. Vogel. In “Sex-Role Stereotypes and Clinical Judgments of Mental Health,” Broverman, Broverman, Clarkson, Rosenkrantz, & Vogel discuss social roles and standards of health. They report, “thus, for a woman to be healthy, from an adjustment viewpoint, she must adjust to and accept the behavioral norms for her sex, even though these behaviors are less socially desirable and considered to be less healthy for the generalized competent, mature adult” (Broverman et al., 1970). As such, feminist therapy emerged to help women understand their experiences and symptoms by developing awareness about the gender-role expectations that have been placed on them by the cultural norms of society.

As a result of the feminist therapy movement, consciousness-raising groups developed, and many women began to develop awareness around the biases that existed in traditional psychotherapy. “Historian Gerda Lerner (1993) defines it as the development of awareness that one’s maltreatment is not due to individual deficits but to membership in a group that has been unfairly subordinated, and that society can and

should be changed to give equal power and value to all” (Brown, 2012, p. 11). As such, feminist therapy evolved out of the need to address mental health issues from non-sexist, non-misogynous, and non-stereotypical approaches. It was developed to reflect many of the concerns of women’s experiences in psychotherapy and the feminist movement. Recently, the efforts of feminist therapy have evolved to address issues pertaining to marginalized populations, including: lesbian, gay, bisexual people, gender variant people, low-income groups, people with disabilities, and immigrants and refugees.

Feminist therapy aims to foster empowerment, create feminist consciousness, develop awareness about social and gender role analysis, resocialize the client, encourage engagement in social activism, and to provide the client with an experience of an egalitarian relationship. Feminist therapists understand the power dynamics that have been created by society and are aware of the impact that this has on the therapeutic relationship. This requires the therapist to reflect on their identities and their privilege. “Feminist therapists take on an ethical obligation as a component of feminist practice to introduce awareness of and, if appropriate, discussions of privilege into the therapeutic environment, owning their greater privilege when it is present, and exploring for themselves the meanings of it when they have less privilege than clients”(Feminist Therapy Institute as cited by Brown, 2012, p. 40). Therapists must remain aware of the client’s level of readiness to introduce these conversations given the discomfort that can often arise when talking about issues of oppression, power, and privilege, particularly as it relates to the impact this may have on the therapeutic relationship.

The theory aims to understand and challenge the realities of the culture and society in which it exists. It understands the dynamics of gender, power, and

powerlessness that exist in society and finds ways to challenge them within the context of the therapeutic relationship (Brown, 2012). In feminist therapy, power is understood under four axes, including areas of somatic power, intrapersonal/intrapsychic power, interpersonal/social-contextual power, and spiritual/existential power. Somatic power refers to the sense of safety that is experienced within the body. It aims to create acceptance within the body and understands the body as a “safe” space. Intrapersonal power refers to one’s ability to trust intuition and become “flexible”. This allows for the experience of emotions and the ability to self-soothe in healthy ways (Brown, 2012, p. 31-37). Interpersonal/social-contextual power refers to one’s ability to develop and maintain healthy relationships, and appropriately end relationships that are unhealthy or problematic. Spiritual/existential power refers to one’s ability to have systems of “meaning making” while remaining connected to reality, and one’s heritage and cultural identity (Brown, 2012, p. 31-37). Understanding these axes can help mental health providers understand multiple areas in which the clients may be feeling disempowered.

When working with women or marginalized groups, feminist therapists challenge the norms and realities that have been internalized by the clients. Brown encourages mental health providers to reframe their perspective. Instead of asking, “what is inherent in women that leads to more depression?” feminist therapists ask “what is it about the conditions of women’s lives in patriarchy that makes depression a common individual manifestation of a larger social problem?” (Brown, 2012, p. 62). The therapist helps the client understand their symptoms and their experiences as a reflection of the social realities they may be internalizing. This can help the client understand the impact that

social and cultural norms may be having on their psychological symptoms and feelings of distress.

Effectiveness & Major Components of Feminist Therapy

Feminist therapy has been applied to a number of diverse populations including refugees and immigrants. It is important to understand the assumptions that are followed when working from a feminist therapy perspective, including assumptions of power, and the challenges that might arise when the client does not assume the same belief. “A challenge to the egalitarian focus of feminist therapy is a person who perceives her/himself as powerless and/or fears becoming powerful because power has been so conflated with abuse” (Brown, 2012, p. 106). In these circumstances, feminist therapists might reflect on themselves and acknowledge the biases and beliefs that are present for them. Since feminist therapy is created as a culturally competent model, its effectiveness can be compared to the existing literature, which supports the theory that culturally competent psychotherapists improves effectiveness (Coleman, 1998; Constatine, 2002, as cited by Brown, 2012).

In their article “Reviewing Effective Components of Feminist Therapy,” Israeli & Santor discuss four core components of feminist therapy and their effectiveness. The following four areas include consciousness raising, social and gender role analysis, resocialization, and social activism.

Consciousness-Raising

Consciousness-raising is a way in which feminist therapy raises awareness around issues of inequality for women. Though it has been found that clients respond to this positively, this intervention has not been found to decrease psychological distress.

However, “Kravetz et al. (1983) found that female participants in a consciousness-raising group reported feeling more capable of solving personal difficulties and internalized feminist values following participation” (Israeli & Santor, 2000). Consciousness-raising has been found to be effective because it allows its participants to understand internalized beliefs and connect with other women’s experiences, thus providing them with opportunities to feel less isolated and more understood (Israeli & Santor, 2000).

Social and Gender Role Analysis

Through social and gender role analysis, clients are encouraged to understand and evaluate the social and gender roles they have been expected to fulfill. The goal is to help women understand how cultural norms have impacted their lives, along with understanding how this may be contributing to their psychological distress. “When working with clients from diverse backgrounds, Comas-Diaz (1994) advocates the use of “ethnocultural assessment” as outlined by Jacobsen (1988) which is a diagnostic tool used to assess a client’s level of ethnocultural identity” (Israeli & Santor, 2000). Research suggests that developing an understanding of social and gender roles provides clients with more opportunities to identify their challenges and adopt different behaviors (Israeli & Santor, 2000).

Resocialization and Social Activism

Resocialization provides women with the opportunity to reframe and expand their roles in a society that have been dominated by Western values. “Initial research on resocialization techniques by Gottlieb *et al.* (1986) reveals that resocialization enables single mothers and abuse survivors to decrease self-blame and to seek opportunities for self-advancement via education and skill development” (Israeli & Santor, 2000). Though

controversial, many feminist therapists find that social activism is essential to therapeutic work. The belief is that “the personal is the political” and change for all women should occur. “There is a conflict in asking women to develop personal autonomy and to then engage in group solidarity and social activism to make advances for that group as a whole without regard to the impact that it may have for individuals” (Parvin & Biaggio, 1991 as cited in Israeli & Santor, 2000). Though some feminist therapists may advocate for social activism as a part of treatment, further research is warranted on the effectiveness of social activism and its impact on the clients.

How Does Feminist Therapy Apply to Transnational Latina Women?

Lillian Comas-Diaz provides an example of how feminist therapy aims to provide cultural competence when working specifically with Latino/a clients. She explains that when working with Central, South American, and Spanish-speaking Caribbean, the therapist must be aware of the “worldviews held by clients from that heritage and culture, particularly to the integration of spirituality and its symbols into people’s lives” (Brown, 2012, p. 110). These worldviews may be expressed through language, sayings and proverbs, spiritual beliefs, social arrangements, rituals, food, and art. She notes that in order to empower the client, a feminist therapist may need to engage in these cultural beliefs, such as sharing a “ritual meal” or attending “a healing event” with the client.

Additionally, it is important for the feminist therapist to be knowledgeable of historical oppression and exclusion. “Feminist therapy, with its precepts of empowering the client, can help Hispanics to better identify and utilize their resources” (Mays & Comas-Diaz, 1988). Understanding the culture of collectivism and the value of family, community and connections can provide mental health providers with more venues of

empowerment. As a result of living in oppressive circumstances in their home countries and in the United States, many transnational Latinas may fear opportunities for empowerment and change. A mental health provider working from a feminist therapy perspective should remain aware of the emotional challenges that change can create for their clients, particularly as this may be the client's first experience addressing their mental health concerns. "In addition the therapist may need to take into account the conflict, feelings of shame, and embarrassment or traitor status that ethnic group members feel when they turn to professional sources" (Mays & Comas-Diaz, 1988). Mental health providers should remain aware and validate the feelings of shame and conflict transnational Latina women might feel upon sharing their emotional lived experiences.

As such, mental health providers working with transnational Latina women should recognize the likelihood that their clients may not be familiar with the experience of voicing and communicating their emotional needs. Somatization has been a way in which many ethnic groups have expressed their psychological distress. It would be helpful for a mental health provider working with this population to remain aware of the different ways in which this population may describe and experience their symptoms of psychological distress.

Furthermore, feminist therapy encourages the therapist to balance power in the therapeutic relationship. While this can provide clients with a sense of empowerment, those working with Latina women should recognize the expectations their clients may have about the role of therapist. "A study conducted by the second author (Comas-Diaz et al., 1982) revealed that Hispanics expected the therapist to be decisive and give advice

while viewing themselves as active participants and assuming an active personal responsibility for the outcome of therapy. Therapists who were not assertive, directive, and decisive were viewed as uncaring” (Mays & Comas-Diaz, 1988). Understanding how this population may view the role of the therapist can help mental health providers adapt the interventions being used, particularly when working from a feminist therapy framework.

The safety of the therapeutic relationship should remain a priority as this population may be experiencing fear, anxiety, and hesitation about how their information will be shared or used against them. Particularly for those women that are living in the United States without a legal status, anxiety about being located can impact their ability to feel safe in the context of therapy and the mental health provider should validate, address, and clarify these fears. Providers working with this population should provide enough space in the therapeutic process to address any questions their clients may have about how the confidentiality process works and how their information will be maintained.

Finally, although this population may be experiencing many challenges and difficulties in this process, it is necessary for the mental health provider to also be aware of the internal resources of strength and coping strategies that may already be in place. Helping this population reflect on the challenges they have already overcome, highlighting empowering beliefs, enhancing coping strategies (prayer, religious/spiritual beliefs, meditation, etc.), can also foster a sense of empowerment within this population. In addition to the external sources of strength this community may have, it would be

helpful for mental health providers to reflect on the internal resilience that may already be in place for many of the Latina women in this experience.

The review of the literature suggests that transnational Latina women are facing various factors that may contribute to their mental health. These factors include the separation of their family members, the traumatic experiences during and after their migration journeys, the stress of challenging their cultural gender roles, and the experience of living with marginalized identities in the United States. If mental health providers are going to be working with transnational Latina women, it is necessary for them to understand the complexity of these experiences and work with culturally appropriate theories and interventions. “Addressing the mental health needs of Latinas requires approaches that are informed by intersection of gender and cultural issues because these methods seek to better engage culturally different populations” (Martinez, Interian, & Waters, 2010). The new APA Multicultural guidelines reinforce the importance of understanding intersectionality of identities. “Intersectionality, by its broadest definition, incorporates the vast array of cultural, structural, sociobiological, economic, and social contexts by which individuals are shaped and with which they identify” (Howard & Renfrow, 2014, as cited in American Psychological Association, 2017). As such, Falicov (2007) encourages mental health providers to think ecosystemically. She identifies three essential factors for working with immigrating populations, including relational, community, and cultural-sociopolitical (Falicov, 2007).

Relationships: As women move to the United States and leave their family members and children behind, relationships change and evolve. Particularly for immigrants, memories of the relationships, and the grief and loss they may experience

over them is an essential factor in their experience, and one that may often lead to feelings of distress. “Relational stress brought about by separations and reunions between parents and children are at the center of the new immigrant experience and thus deserve special attention” (Falicov, 2007). Immigrant women from Latin America may find themselves reframing the experience of separation and providing long-distance care to their loved ones, and often relying on other caretakers in the family to provide ongoing support for the members left behind. As such, Falicov (2007) suggests mental health providers encourage immigrants to maintain connections with their family members back home via phone, email, letters, and to maintain rituals of providing for their families back home. It is recognized that, although maintaining connections may initially create feelings of distress, maintaining connection might allow for immigrants to experience a sense of “presence” (Falicov, 2007).

Community: Immigrants in the United States may also experience a sense of loss of their community. Mental health providers working with immigrants, particularly immigrants from collectivist cultures, may find it helpful to realize the importance of maintaining community and relationships. Community can continue to be created through spiritual and religious affiliations, but, additionally, community can also be an opportunity for long-term immigrants to help those who have more recently arrived to the United States (Falicov, 2007). These opportunities would not only provide immigrants with a sense of connection and community, but would also allow for those immigrants that have been in the United States for longer periods of time to help others make “empowering changes” (Falicov, 2007), while helping themselves maintain motivation and encouragement.

Cultural-Sociopolitical: When working with Latina immigrants, mental health providers must remain aware of the issues of oppression, power, and diversity that are impacting their client's health and the therapeutic relationship. "Cultural diversity positions questions therapists' uncritical imposition of normative mainstream values and encourage therapists' cultural examination of person and conceptual preferences" (Falicov, 2007). Mental health providers are encouraged to acknowledge the power dynamics inherent in the therapeutic relationship and apply interventions of critical consciousness, empowerment, and accountability (Falicov, 2007).

Applying Feminist Therapy to Relationships, Community, and The Cultural and Sociopolitical Contexts: How can We Apply Feminist Therapy's Main Components to These Contexts in an Effort to Address the Identified Concerns?

1. Consciousness-raising has always been a therapeutic component of feminist therapy. "As a therapeutic mechanism, it helps women realize that they are not the sole cause of their distress and that others share their problems" (Israeli & Santor, 2000). Not only does consciousness-raising foster a sense of community among women experiencing similar experiences and distress, but it enhances the possibility for connection with others, thus providing them with opportunities to maintain and develop relationships. Feeling like something as valuable as the relationships and communities in their lives have been lost can contribute to the feelings of distress, loneliness, and sadness. The therapist can help the women understand the value that a sense of connection and community may hold for them. Through empathic reflection and a safe space for self-exploration, the therapist can help immigrant women engage in opportunities to continue

enhancing meaningful and valuable relationships in their lives. “Rogers argues that factors such as therapist empathy, consistency, and unconditional positive regard lead to positive change for clients” (Israeli & Santor, 2000). Consciousness-raising can provide immigrant women with the insight to reframe their experiences and relationships. In doing so, immigrant women might perceive new opportunities to relate and maintain or develop relationships with their loved ones or members in their community. Reframing the experience might allow immigrant women to reflect on the sense of loss and grief they may be experiencing about their relationships while connecting with other women that may be sharing similar feelings of distress, thus reducing feelings of shame and guilt.

2. Through social and gender role analysis, women are able to develop a better understanding of the impact of cultural norms. Women are provided with an opportunity to understand how their role in a patriarchal society, as women, has impacted their self-perception and psychological distress. “The therapist assists the client in identifying the message she has received across the lifespan and their impact” (Israeli & Santor, 2000). Reflecting on social and gender roles can provide immigrant women with the insight that might help them understand the distress they may be experiencing as they face the gender roles established in their communities at home, and how their marginalized identities may be impacting their lived experience in the United States as immigrant women. As previously noted, being away from their families, and often children, has led to greater psychological distress. The distress may be a result of numerous factors, but may also be a result of facing a decision that has challenged their roles as being the primary caretakers at home. As a result, making the decision to migrate in order to provide their children and families back home with a better life may often leave women experiencing feelings of

shame and guilt. Working with this framework can provide women with the opportunity to understand their symptoms as a result of the norms and expectations that have often been placed on women across various cultures. By providing women with the space to reflect and develop self-awareness about their roles and lived experiences in society, components of feminist therapy can help women reflect on their roles and contributions to their families and communities, and ultimately provide them with the opportunity to make informed decisions for themselves and their families.

3. Social activism has been recognized as another key component of feminist therapy. Many have found this to be a controversial factor, as it is uncertain how effective it may be for clients to merge the personal with the political. Nevertheless, social activism can serve as an opportunity to provide Latina immigrants with a sense of empowerment and self-acceptance. “Participation may lead to a sense of personal empowerment and a sense of affecting broader societal changes that will improve the mental health of all women and society” (Israeli & Santor, 2000). Reflecting on ways in which a sense of empowerment may or may not be helpful to their lives should precede any encouragement for activism or movement. Typically, social activism has included involvement in organized protests, writing letters, or involvement in groups or associations of specific interests (Israeli & Santor, 2000). However, mental health providers including social activism as an intervention need to remain aware of the additional systemic barriers Latina immigrants may be facing. Fear of deportation and previous experiences of being silenced and marginalized may prohibit this population from speaking out and voicing their concerns. Mental health providers working with this population need to develop an understanding of the reality of the systemic barriers and

avoid pathologizing the client's fear or symptoms of anxiety around these activities. If a mental health provider decides to include social activism in their treatment, it would be beneficial to develop new approaches which respect the client's experience as they navigate living with multiple marginalized identities. While social activism can be used for empowerment, safety concerns need to be prioritized in this context. The role of the mental health provider would be to assess for opportunities in community involvement and help their clients decide if these opportunities would foster strength and empowerment without compromising the client's sense of safety in his or her community. The following visual has been developed to help mental health providers understand how key components of feminist therapy, including consciousness-raising, social gender and role analysis, and social activism can be applied to the identified ecosystemic contexts when working with transnational Latina women around their community, relational, and cultural and sociopolitical roles.

Application of Theory Example: How Feminist Therapy Factors can Help Mental Health Providers Address Identified Concerns for Transnational Women from Latin American Countries

<p style="text-align: center;">1. Conciouness-Raising</p> <p style="text-align: center;"><u>Community*</u></p> <p style="text-align: center;">Creates opportunity to learn about similar experiences of distress</p> <p style="text-align: center;">Provides opportunities for new development of relationships</p> <p style="text-align: center;"><u>Relationships*</u></p> <p style="text-align: center;">Connections are created and opportunities to relate and understand each other are formed</p>	<p style="text-align: center;">2. Social Gender and Role Analysis</p> <p style="text-align: center;"><u>Cultural & Sociopolitical roles*</u></p> <p style="text-align: center;">Develop understanding of issues of oppression and marginalization based on identities and socially created roles; understand gender roles and impact of social expectations on symptoms of distress</p> <p style="text-align: center;"><u>Community*</u></p> <p style="text-align: center;">Creates space to reflect on contribution to families and community</p>	<p style="text-align: center;">3. Social Activism</p> <p style="text-align: center;"><u>Empowerment</u></p> <p style="text-align: center;">Understand complexity of diversity & various forms of empowerment</p> <p style="text-align: center;">Opportunity to be involved in social change and help others</p> <p style="text-align: center;">Acknowledging importance of strength found in relationships</p> <p style="text-align: center;"><u>Self-Acceptance</u></p> <p style="text-align: center;">Developing strong sense of identity and lived experiences</p>
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* Items are contexts identified in Falicov's ecosystemic model (Falicov, 2007).

How This Model Can Help Mental Health Providers Address the Presenting Concerns of Transnational Women from Latin America

As previously noted in the literature, transnational women may experience various circumstances that may lead to feelings of fear, depression, loneliness, sadness, stress, and in some circumstances, the possibility of developing PTSD symptoms. Mental health providers working with this population should not only be aware of the possible symptoms this population may experience, and the differences in how they might be experienced (i.e., consider somatization), but it can be helpful to understand how feminist therapy can be useful to better understand the development and experience of these symptoms. Mental health providers working from a feminist therapy perspective might ask themselves something that resembles the following question, “what is it about the conditions of women’s lives in patriarchy that makes depression a common individual manifestation of a larger social problem?”(Brown, 2012, p. 62). In the case of working with transnational immigrant Latina women, a mental health provider might ask themselves the following: What is it about the conditions of these women’s lives (as it relates to their life in their home countries, their lives in the United States, the experiences during the migration process, and the internalized messages of oppression and marginalization) that may be impacting their symptoms? Working from this perspective could not only help the mental health provider develop a deeper understanding of the larger system circumstances impacting their client’s experiences and symptoms, but it can also provide them with the opportunity to apply the key components of feminist therapy (consciousness-raising, social and gender role analysis, and social activism) to help their clients cope with the identified concerns for this population:

developing stronger relationships, finding a sense of community, and developing awareness of the sociocultural roles impacting their experiences. In doing so, mental health providers can help transnational Latina women feel more understood and less alone in their experience. The key components of feminist therapy can help the women understand their distress while also providing them with opportunities for empowerment, self-acceptance, and strength.

Suggestions for Mental Health Providers Working With Latina Women and Feminist Therapy

The following suggestions have been developed to assist mental health providers working with Latina transnational women. These guidelines have been created for providers working with Latina transnational women in the context of community health centers, in which there can be a variety of treatment lengths. The following guidelines may be most effective in individual treatment but can be modified to fit the needs of a group experience. Developing a therapeutic space for groups can help meet many of the perceived needs of this population including community and relationships. The goal of the suggestions is to help mental health providers understand how key components of feminist therapy, including consciousness-raising, social gender and role analysis, and social activism can strengthen the therapeutic alliance and create a space for mutual reflection and exploration.

Guide for Mental Health Providers

- Recognize and prioritize need to clarify confidentiality and safety in therapeutic relationship
- Provide clients with space and time to become familiarized with therapeutic process and allow them to ask questions about the process

- Remain sensitive to feelings of fear/ hesitation of engaging in therapy and normalize these hesitations and challenges
- Consider limitations in client's ability to return to therapy, and consider other sources of support early in treatment (religious communities, therapeutic groups, and well-known spaces in community)
- Accept loss of relationships and validate evolution and changes of current relationships/ Foster new sense of connection between the client and their family members and friends back home
- Consider stages of development for children and family members back home and encourage developmentally appropriate forms of connection with them
- Remain aware of somatic experiences and symptoms and normalize experience while providing education on these concerns
- Apply the concept of consciousness-raising in an effort to help clients understand sources of their distress
- Recognize areas of power and privilege in therapeutic relationship and validate feelings of helplessness and powerlessness which they might continue to experience in the context of their identities
- Foster internal resources of strength and resilience; remind clients of the abilities, skills, and coping strategies which they have already been using (e.g. religion)
- Reflect on themes of community, relationships, and cultural and sociopolitical roles
- Use social and gender-role analysis as an opportunity to help the client understand internalized issues of oppression and marginalization based on identities
- Reflect on the impact of social activism as an opportunity to foster community and empowerment
- Engage in dialogues involving issues of oppression, privilege, and power
- Examine expectations and assumptions of women in society
- Understand the impact of possible historical systemic traumas (refer to literature on topics such as liberation psychology), and the impact of the migration experience
- Remain flexible in therapeutic style

Feminist Theory in Practice: A Composite:

Fatima is a 31-year-old, heterosexual, Spanish-speaking woman from Honduras. She is a single mother of two children, ages seven and four, and has recently moved to the United States from Honduras in order to work and send money back home to her family. Fatima arrives to the community mental health center because her primary care physician referred her. She reported feeling confused about why she was referred for mental health treatment as she feels that many of her symptoms are physical. Additionally, Fatima appears to feel hesitant to share information about her history as she fears that the information will be shared with outside resources. After clarifying the limitations of confidentiality, Fatima begins to share more about her experience. When asked about her symptoms, Fatima described shortness of breath, shakiness, racing thoughts, and moments in which she feels “muy nerviosa” (very nervous). Moreover, Fatima reported feeling fatigue, lack of interest in activities she normally enjoys, inability to sleep, reduced appetite, and persistent feelings of sadness. Fatima reported that many of her symptoms started since she moved to the U.S. two years ago. When asked about her family further, Fatima reports that her children have remained with her mother and sister in Honduras. She works as a full-time nanny for a local family and receives payment in cash as her undocumented legal status limits her ability to work. Fatima earns minimum wage and sends most of her money back home to her children, her mother, and her sister. As a single mother in Honduras, Fatima felt that she did not have much choice but to leave her home in order to help support her family. Due to the economic stressors and limited opportunities in Honduras, Fatima decided to leave her home in order to provide a safe upbringing for her children. One of her main goals in life is that her

children will grow up in an environment in which they will not have to worry about violence and safety concerns. As she describes her experiences since leaving her home in Honduras, the memories of her journey into the U.S., and the lifestyle she has been living since living in the U.S., Fatima begins to cry and share how alone and guilty she has been feeling. When asked about how she has been coping, Fatima speaks to having a strong religious faith but explained that she has been isolating herself from church as she fears that others will judge her for having left her family behind.

Application of Guidelines:

At the introduction of therapy, the mental health provider working with Fatima might want to spend some time explaining the confidentiality process and reassuring her of ways in which the security of her information will be maintained. The provider will want to provide enough time and space for Fatima to ask any clarifying questions she may have in regards to the therapeutic process. The mental health provider can normalize the fears and hesitations she might be having about this experience and provide her with education about the ways in which therapy can be helpful for the symptoms she might be experiencing. Education about the therapeutic process and education about the physical experience of her symptoms can help normalize any doubts and hesitations Fatima might have about therapy.

In addition, the provider may take some time to acknowledge the power dynamics that might be present in the therapeutic experience (based on different roles in the relationship and/or identities) and validate how powerless and helpless Fatima may have been feeling in the context of her marginalized identities as a Latina immigrant woman living in the U.S. Given cultural expectations of providers, and her limited experience in

mental health treatment in the U.S., it may be that Fatima arrives to therapy with certain expectations from the provider. She may perceive the provider as an “expert” and might prefer a more directed and approach. It would be helpful for the mental health provider to recognize Fatima’s expectations and reflect on his or her own therapeutic style and approach. As the mental health provider reflects on this dynamic, it would be helpful to be aware of Fatima’s identity development and what her needs might be at the moment. Fatima may find relief in having the mental health provider recognize their power in the therapeutic relationship, but it may also be that Fatima finds safety in working with a provider whose therapeutic style aligns with her cultural expectations or providers.

Consciousness raising. Early in treatment, the mental health provider working with Fatima can help her identify **community** and places of support. Support groups, psychoeducational groups, and religious communities (Spanish-speaking) can provide Fatima with the opportunity to connect with other people who might be sharing similar experiences. This can help Fatima feel understood and feel more connected to the people around her. Finding community can help Fatima cope with her feelings of loneliness and provide her with an opportunity to build new **relationships** which will provide her with emotional support and validation. Addressing her fears of judgment from others, and normalizing this fear as she becomes more conscious of gender roles, can help reduce some of the shame Fatima might be feeling about her decision to have left her children behind.

Social gender and role analysis. The mental health provider working with Fatima can help her develop a deeper understanding of the psycho-somatic symptoms she might be experiencing, normalize them, and provide her with a deeper understanding of

how many of her symptoms may continue to be impacted by her **cultural and socio-political roles**, and her on-going experience of oppression and marginalization.

Treatment can be used to help Fatima understand why she might be feeling so much shame, guilt, and anxiety about having left her children in Honduras. The mental health provider can help Fatima reflect on her identities and the gender roles she has been expected to live up to as a result of cultural beliefs and her identities. Therapy can be used as a way to explore the pressure or sense of disappointment Fatima might be feeling from her family members, and other women in her home. Due to the cultural expectation that women are the primary caretakers of the home, it may be that Fatima is experiencing a sense of judgment, rejection, or shame, and this may be contributing to her overall distress. Similarly, therapy can help Fatima recognize her feelings of powerlessness and helplessness, particularly as she continues to feel minimized by her legal status, her inability to speak fluent English, and the oppression she may continue to experience as a woman of color in the United States. Similarly, suggestions could be made for Fatima to connect with her family to maintain a sense of connection, as well as with other women experiencing similar stories so that she continues to build relationships and a sense of **community** with others. These interventions can include helping the clients access means to communicate with their families more consistently via phone, video calls, or helping them identify what they might want to write and communicate to their loved ones back home. The mental health provider can also help Fatima reflect on ways in which she continues to remain connected, if not physically, through her actions and support.

Therapy can be used as a space in which Fatima reflects on her strengths and values that have encouraged her to make such a difficult decision. Furthermore, the mental health

provider can help Fatima reflect on activities she enjoys and find opportunities in her community to join. This can help Fatima regain a sense of connection to her community while also working on maintaining connection with her family from home.

Social activism. Developing a deeper understanding of her identities and her decisions can help Fatima reduce her feelings of shame and gain more **self-acceptance**. Working on developing a strong sense of identity and accepting her lived experiences can help Fatima work towards **empowerment** of herself and others. Therapy can help Fatima become aware of ways in which she can reflect on her internal sources of strength (religious views, family values, sources of motivation), resilience, and gain a sense of empowerment over her decisions in a way that aligns with her values and beliefs. Recognizing her fears and her legal limitations, the mental health provider should help Fatima identify opportunities for empowerment that align with her values and that do not compromise her sense of safety in her environment.

Limitations of the Application

Although feminist therapy aims to create a sense of empowerment in marginalized populations, it would be helpful for mental health providers working from this framework to understand the values and assumptions that are often being made when working from this theory. Feminist therapy was developed in the United States, which largely follows culturally individualistic values and goals. Mental health providers should remain aware of the differences in values derived from individualistic and collectivistic cultures, particularly as they work with transnational Latina women. Additionally, mental health providers should examine and reflect on their own personal values and roles as they relate to their identities and experiences of privilege and/or

oppression. Taking the time to self-reflect and become aware of one's own biases and assumptions can help mental health providers explore transnational Latina women's lives with examined assumptions on values of social gender expectations.

Furthermore, feminist therapists should remain aware of the emotional and social challenges transnational Latina women might experience when introducing interventions of empowerment and self-advocacy. Though many women of this population could benefit from opportunities to become active members of the community and engage in self-advocacy activities, other women may continue to experience fear and anxiety in their everyday lives. This may be a result of continuing to feel threatened in their environments, particularly if they initiate behavior changes as they continue to live in oppressive circumstances or relationships. Mental health providers working from a feminist therapy framework should remain aware of the reality of the circumstances their clients may be continuing to face. Feminist therapists should develop a more profound understanding of the complexity of their client's past and current experiences and provide appropriate interventions.

Future Research

Understanding the social contexts and the emotional challenges transnational women from Latin American countries face can help mental health providers adapt and modify relevant and appropriate interventions to help meet the client's needs. Feminist therapy is a framework which can be used with other interventions and theoretical orientations. As such, this framework can be adapted to the needs of the population and be used with other forms of intervention that would best address the shared experiences of many transnational women from Latin America. Further research could incorporate

literature on liberation psychology, as this could capture the historic social context impacting this group's psychological health. First articulated by Martín-Baró, liberation psychology developed out of the need to address the needs of the oppressed. "In the context of South America, Martín-Baró (1994) argued that Western psychology had very little to offer in terms of the region's severe and oppressive circumstances, particularly as it relates to the experiences of people in South America" (Tate, Rivera, Brown, & Skaistis, 2013). Future research and incorporation of theories such as liberation psychology can provide mental health providers with a deeper historical understanding of the oppressive historical circumstances their clients may have been experiencing. Additionally, future research involving case study examples can help mental health providers review strategies of application. Recruitment of this population may create difficulties due to uncertainty of confidentiality, and as such, future research should consider specific strategies to address these challenges.

Summary

A review of the literature suggests numerous circumstances impacting the overall well-being of transnational Latina women. It would be helpful for mental health providers to develop a deeper understanding of the complexity of systemic and individual factors impacting their client's experience. These factors may include systemic experiences of marginalization, oppression, cultural beliefs, challenging gender roles, and individual experiences of loss and trauma. Feminist therapy can provide mental health providers working with this population with a framework to understand the depth and complexity of these issues. Understanding how concepts of community, relationships, and sociopolitical roles can help this population, mental health providers can adapt and

modify their interventions. Mental health providers can work from a feminist therapy perspective to provide their clients with a sense of empowerment while continuing to respect and validate cultural values.

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