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Predictors of burnout for immigrant mental health professionals in the United States

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Abstract

Mental health professionals who identify as immigrants encounter personal and professional barriers that can impact overall wellbeing. The current study conducted a survey of 108 licensed mental health professionals who identify as immigrants practicing in the United States. The survey included demographics as well as assessments of burnout, social support, and migratory grief and loss. The results of this study highlighted that a combination of higher migratory grief and lower perceived social support significantly predicted higher levels of burnout in mental health professionals. Implications for mental health programs, supervisors, and mentors and suggestions for future research are provided.

KEYWORDS

burnout, grief, immigrants, mental health, trauma

PREDICTORS OF BURNOUT FOR IMMIGRANT MENTAL HEALTH PROFESSIONALS IN THE UNITED STATES

Immigration is a life-change generally made to improve one's overall quality of life and well-being, while also increasing risk of challenges that can impact mental health and overall well-being. According to most literature on immigrant mental health, successful adaptation to the host country, including overcoming occupation, language, and other barriers, is an essential part of the immigration process (Delara, 2016). Issues immigrants oftentimes encounter that can impact their overall well-being include discrimination, societal prejudices, occupation changes, migratory grief and loss, language, and education barriers (Aroian et al., 2003). Burnout and secondary traumatic stress are risks for mental health professionals due to the nature and demands of their work (O'Connor et al., 2018). Thus, for mental health professionals who are immigrants, there may be escalated risk of burnout and trauma.

This study is framed in the Ecological Systems theoretical model (Bronfenbrenner, 1992). The Ecological

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Systems model describes how various systemic influences directly and indirectly impact individuals. Bronfenbrenner's nested model include five interrelated systems that expand from direct influence (e.g., family) to environmental longitudinal changes. The systems are as follows: the microsystem (direct contact with the person), the mesosystem (interactions between the person and their community), the exosystem (community influence), the macrosystem (cultural ideology), and the chronosystem (longitudinal change). Within the current study, various systemic influences (e.g., family, coworkers, healthcare systems, immigration systems) influence the experiences of mental health professionals who are immigrants in the United States. The constructs of migratory grief and loss, presence of social supports, and impacts of mental health services work represent the intersection of individual variables and systemic variables to form an ecology that inevitably shapes the immigrant clinician experience.

MIGRATORY GRIEF AND LOSS

Heavily influenced by the micro, meso, and exo systems, the process of immigration contributes to profound losses and disruptions in identity (Berger et al., 2004).The result is the loss of the cultural self and the need to reconstruct a self that integrates the original culture while meeting the demands of the new macrosystem (Martínez Rosas, 2020). Kuo (1976) and Espin (1987) were the first two researchers who claimed a relation between migration experiences and potential psychological distress. They described migratory grief as the consequence of immigration, relocation and resettlement being the disconnection of both the symbolic and physical self. This disconnection in self can be as a result of separation from the old exosystem, including but not limited to the climate, food, community, laws and practices (Espin, 1987; Kuo, 1976). In essence, it's an individual reaction to variables that trigger changes across systems that influence one's thoughts, feelings, and behaviors.

The manifestation, extent and intensity of migratory grief continues to be under-studied. Oftentimes, research on immigrants place significant emphasis on the achievement of adjustment and assimilation, while attending to challenges faced and coping mechanisms developed. Migratory loss specifically is often overlooked by both researchers and immigrants, with some postulating that it's because reflecting on loss can heighten a sense of doubt about their choice to migrate and heighten distress (Kuo, 1976). Thus, understanding the implications of migratory loss can offer critical insight into the migration and relocation experience. Currently, there are no studies that have examined the implications of migratory grief on immigrant mental health professionals and their overall wellbeing.

SOCIAL SUPPORT

Bronfenbrenner (1992) believed that the interaction between a person and their community (the exosystem) was essential for healthy development. Immigrants experience the loss of many sustaining social, personal and professional relationships within the exosystem, as well as defined roles that help facilitate meaning of their cultural and communal connection in the macrosystem (Suarez-Orozco et al., 2005). Research has evidenced that social support has significant positive effects on immigrant mental health, including amplifying sense of belonging, companionship, and sense of self-worth (Garcini et al., 2021; Herrero et al., 2011). Not only does social support act as a buffer against the impact of stress, but it can also ameliorate against symptoms of depression, anxiety, and schizophrenia in immigrant populations (Bhugra, 2004).

Ultimately, research continues to point to the positive relationship between social support and the mental well-being of immigrants (Salinero-Fort et al., 2015; Siedlecki et al., 2014; Zhou & Lin, 2016). In fact, Fernández et al. (2015) have suggested that social support operates as a protective resource for promoting well-being among immigrant populations. Hinojosa and Carney (2016) who studied Mexican American women pursuing Counselor Education doctoral degrees found that faculty and peer support was essential for academic success. Currently, there are no studies that examine the perceived social support among immigrant mental health providers and its overall implications on their wellbeing.

Migratory grief and loss in addition to social support post-migration are issues that are specific to the immigrant population and lead to significant dysregulation in their ecological systems. Immigrant mental health professionals have to navigate systemic challenges in both the post-migratory arena and issues inherent to their profession. In the next section, we will discuss burnout risks for mental health professionals and how it might affect immigrant subpopulation.

BURNOUT FOR MENTAL HEALTH PROFESSIONALS

For a mental health professional, the exosystem could include the community they work in, government agencies regulating their job, licensing, and income, mass media, and services available for both the professional and their clients. In a sample of 1121 mental health providers, Sprang et al. (2007) found that approximately 13% were at high risk for compassion fatigue or burnout. Likewise, in a sample of 327 psychotherapists, Spännargård et al. (2022) found that 62% reported moderate to

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high levels of burnout due to personal or work-related issues, often influenced by variables that dysregulate the exosystem. Furthermore, for immigrant mental health professionals, they are also balancing a new macrosystem. Barreto (2013) found that immigrant psychotherapists who work in the United States deal with culture shock and a sense of belonging nowhere, which leads to multiple stressors that can contribute to feelings of vulnerability surrounding their professional identity. There were similar findings in Kissil et al. (2013) study of immigrant therapists' acculturation and counseling self-efficacy. Results demonstrated that the more acculturated the immigrant therapist described being, the higher they perceived their self-efficacy. However, this may come at a cost. A study with immigrant students in counselor education found that while acculturation of euro-normative behaviors helped participants navigate their professional identity, they felt in order to be their cultural authentic selves, they had to hide their heritage culture values and behaviors (Interiano & Lim, 2018). Understanding systemic factors of immigration that contribute to burnout for mental health professionals could help to inform training and professional support for this population of clinicians. Currently, there are no studies that examine burnout among immigrant mental health providers and its overall implications on their wellbeing. Thus, the purpose of the current study is to understand the impact of systemic factors including social support, migratory grief and loss, and presence of family on burnout for mental health clinicians who are immigrants in the United States.

METHODS

Researchers conducted a broader study with the purpose of exploring factors impacting the wellness and experiences of mental health professionals who identify as immigrants in the United States. This study used one-stage embedded mixed methods design (Creswell & Plano Clark, 2017) including quantitative assessments and open-ended qualitative questions in an online survey. The current inquiry is a quantitative analysis of the survey portion of this broader dataset. From this broader data set, the research question that guided our current analysis was: To what extent does perceived social support, migratory grief and loss, and family in the US predict burnout scores for immigrant mental health providers?

PARTICIPANTS

The general study included participants who identified as immigrants in the United States. Inclusion criteria were (1) individuals who identify as immigrants in the United States and (2) individuals who are licensed or certified mental health professionals practicing in the United States. Researchers broadly defined immigrants as (1) individuals who were born in a country besides the United States and immigrated to the United States at any point after birth, (2) individuals who have begun or completed the naturalization process to become a United States citizen, or (3) individuals who were born in the United States but lived a significant portion of their lives in another country. There were 289 responses to the survey overall, after data cleaning 108 (37.3%) participants met the criteria and completed all the assessments in the survey although some chose not to disclose certain demographics. A priori power analysis was conducted using G*Power version 3.1.9.6 (Faul et al., 2009) indicated a minimum sample size of 77 was needed to identify a medium effect at $\alpha = 0.05$ and power = 0.80.

Research focused on mental health professionals at the master's level of practice, which included Professional Counselors (n = 54, 50.0%), Marriage and Family Therapists (n = 10. 9.3%), Social Workers (n = 37, 34.3%), Addictions Specialists (n = 3, 2.8%), School Counselors (n = 2, 1.9%), and Psychologists (n = 1, 0.9%). Professionals indicated if they were fully (n = 74, 68.5%) or provisionally (n = 30, 27.8%) licensed in their state. Professionals practiced in rural (n = 14, 13.0%), urban cluster (n = 43, 39.8%) and urban (n = 50, 46.3%) areas. The average years of experience was 10.1 years (SD = 10.1) with a range of one to 45 years of practice.

Overall, participants identified as male (n = 21, 19.4%), female (n = 85, 78.7%), nonbinary (n = 1, 0.9%), or transgender (n = 1, 0.9%). The average age of participants was 43.94 years (SD = 12.5) with a range of 22 to 74 years. Participants had been in the United States for an average of 27.2 years (SD = 14.7) with some participants only being in the United States for 1.5 years and some as many as 50 years. Participants indicated their self-identified race and ethnicity. Participants self-identified as White/Caucasian/European (n = 42, 38.9%), Black (n = 3, 2.8%), Hispanic/Latinx (n = 26, 24.1%), Korean/Chinese/Japanese (n = 13, 12.0%), Middle Eastern (n = 4, 3.7%), West Indian/Caribbean (n = 2, 1.9%), Jewish (n = 3, 2.8%), Indian/Sri Lankan (n = 7, 6.5%), African (n = 2, 1.9%), Pacific Islander (n = 1, 0.9%), and Bi/Multi Racial (n = 3, 3.7%). Participants also indicated their religion or spirituality. Participants self-identified as Christian (n = 22, 20.4%), Catholic (n = 13, 12.0%), Muslim (n = 3, 2.8%), Jewish (n = 5, 4.6%), Buddhist (n = 2, 1.9%), Agnostic (n = 9, 8.3%), Atheist/Non-Religious (n = 22, 20.4%), Generally Spiritual (n = 23, 21.3%),

Taoist ($n = 2$, 1.9%), Hindu ($n = 1$, 0.9%), and Multi-Religious ($n = 1$, 0.9%).

PROCEDURES

The current study was approved as exempt by the University of Wyoming Institutional Review Board and the national institutional review board for the National Association for Social Workers (NASW). This study was supported by a grant from the [internal grant source] at the [university]. Recruitment for the study included email solicitation to individual professionals and professional associations. NASW state branches required approval from their internal Institutional Review Board prior to advertising the study. Researchers posted on professional listservs and reddit forums related to mental health professionals. Researchers reached out to state branches of professional organizations to solicit members (e.g., ACA, AAMFT, NASW, NAADAC, AMHCA).

The researchers solicited licensing boards for all 50 states to obtain contact lists of mental health professionals that met the criteria for participation in the study. Contact lists were obtained from licensing boards in the following states: Vermont, North Dakota, West Virginia, Wyoming, Nebraska, Oregon, Arkansas, and North Carolina. Beyond licensing boards, researchers obtained email contact for mental health professionals via the US Doctor Database to contact mental health professionals in all 50 states.

The email solicitation included a description of the study and a link to a Qualtrics survey that contained the informed consent, demographics questionnaire, open-ended survey questions, and assessments. As an incentive, participants were offered access to a 1 h telehealth ethics webinar created by the researchers. Upon completing this webinar, participants could take a short quiz and download a continuing education certificate that should meet criteria for state licensing renewal in most states. The survey was anonymous, and the information collected for the continuing education certificate was at all connected to the survey responses.

INSTRUMENTATION

This analysis included data from a broad dataset which included a demographics questionnaire, open-ended qualitative questions, and a total of five assessments. The current research questions focus on demographics factors of family supports in the United States and the Migratory Grief and Loss Questionnaire (MGLQ; Casado et al., 2010), Professional Quality of Life Scale (ProQOL; Stamm, 2010), and the Multidimensional Scale of Perceived Social Support (MSPSS; Zimet et al., 1988). All assessments are based on self-report.

Multidimensional scale of perceived social support

The MSPSS has 12 items and measures subjective assessment of the adequacy of received emotional social support (Zimet et al., 1988). Construct validity has been confirmed by several studies (e.g., Cecil et al., 1995; Kazarian & McCabe, 1991) as well as reliability (Cecil et al., 1995; Dahlem et al., 1991). This assessment has three subscales which measure various sources of social support (Zimet et al., 1988): Significant Other (Cronbach $\alpha = 0.91$), Family (Cronbach $\alpha = 0.87$), and Friends (Cronbach $\alpha = 0.85$). The reliability of the overall scale was strong (Cronbach $\alpha = 0.88$). For the current analysis, researchers only used the total score.

Professional quality of life scale

ProQOL is the fifth edition of this instrument. ProQOL has 30 items and measures quality of life for human services professionals using a five-point likert scale (Stamm, 2010). This instrument is translated into 28 languages and widely used to explore burnout and quality of life for professionals. ProQOL includes three subscales which are scored and used independently: Compassion Satisfaction, Secondary Traumatic Stress, and Burnout (Stamm, 2010). In each item, participants indicated how often they experienced events in their current work setting in the last 30 days. The current analysis uses the Burnout subscale (Cronbach $\alpha = 0.83$; Cieslak et al., 2014) which describes hopelessness and challenges in work tasks.

Migratory grief and loss questionnaire

The MGLQ has 20 items and measures the grief experience associated with immigration. Scale has internal consistency, reliability, and concurrent validity as demonstrated by predicted relationships with depression scores (Casado et al., 2010). The instrument overall was developed to incorporate factors of migratory grief and general grief and loss. The instrument has a strong overall internal consistency (Cronbach $\alpha = 0.94$) with valid translations in several languages (Casado et al., 2010). MGLQ assessed three dimensions of grief and loss including searching and yearning, nostalgia, and disorganization. The assessment uses a Likert scale to assess intensity of migratory grief. The

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assessment does not have delineated scores for levels of migratory grief.

ANALYSIS

Following data collection, data were transferred from Qualtrics and analyzed with SPSS version 28. Data was cleaned and screened for missing data. The total number of participants that began the study were 289; however, 108 completed all the assessments and were used for data analysis. Researchers conducted a visual analysis for missing data and found that 0.24% of the data had missing values. As the missing data were almost negligible (0.24%, multiple imputation methods are recommended when the missing data is more than 5%), and missing data were related to the likert scale ratings, item mean was used for replacing missing data (Downey & King, 1998; Jakobsen et al., 2017.) Univariate values were explored to assess data for normality. Skewness index values on the continuous variables ranged from −1.10 to 0.57 and did not exceed the recommended absolute value of 2 and kurtosis index values did not exceed 7.0 (George & Mallery, 2022); therefore, the assumption of normality was met. Multicollinearity was checked by exploring tolerance and the variance inflation factor (VIF) as well as the correlation matrix; multicollinearity among the variables was not indicated. The central tendency and variability in the data were summarized and described using descriptive statistics, which included mean and standard deviation. The correlation between the variables was calculated using Pearson correlation. A burnout prediction model was created using multiple regression analysis. By analyzing the plot of the residuals versus the anticipated values, we evaluated the homoscedasticity assumption. The plot showed that the variance of the residuals was approximately constant across all levels of the independent variables, indicating that the assumption of homoscedasticity was met. Further, based on the initial model and the semi-partial correlation between dependent and independent variables, we developed a parsimonious model by removing independent variables that did not contributed significantly to the model.

RESULTS

The current research considered constructs of social support, migratory grief, burnout, and elements of support (see Table 1). The outcome of the Burnout subscale of the ProQOL (Stamm, 2010) had an average score of 21.62 (SD = 6.0). A score of <22 indicates a low level of burnout. For the MSPSS (Zimet et al., 1988), the overall score for participants was an average of 68.4 (SD = 12.6). A score of more than 61 indicates a high level of social support. For the MGLQ (Casado et al., 2010) the average participant score was 40.3 (SD = 11.5), with a maximum possible score of 60. On MGLQ, a higher score indicates more intensity of grief.

Participants were asked if they have family in the United States. The majority (n = 95, 88.0%) of participants did have family in the United States, although some did not (n = 13, 12.0%). For those with family in the United States, when asked how far away their family was located, participants generally had some family closer than 50 miles (n = 46, 42.6%), 51–100 miles away (n = 12, 11.1%), 101–150 miles away (n = 2, 1.9%), or more than 150 miles away (n = 35, 32.4%). Participants also indicated how they kept in contact with family members. Some participants did not have contact with family (n = 10, 9.3%), many had contact with family in-person (n = 42, 38.9%), using real-time audio or video contact (n = 30, 27.8%), or with asynchronous contact such as email or text (n = 13, 12.0%).

To explore and develop a model to predict burnout (dependent variable) among the mental health professionals, we started with the following independent variables: MSPSS, MGLQ, age in years, number of years of stay in the US, and having family in the US. Among all the variables, Pearson correlation analyses indicated MSPSS, MGLQ, and age sharing a significant correlation of −0.32, 0.25, and −0.20, respectively, with burnout. However, years of stay in the US and having other family members in the US indicated non-significant correlation of −0.08 and − 0.01, respectively, with burnout.

The multiple regression model with all the five predictors produced F (5,100) = 5.653, $p < 0.001$, accounting for 22% (R^2 = 0.22; adjusted R^2 = 0.18) variance in the burnout scores. The MSPSS predictor had a significant negative regression weight (with the highest semi-partial correlatio$n$ = −0.37), indicating participants with higher perceived social support scores were expected to have lower burnout scores, and MSPSS contributed high unique variance to the model (see Table 1). Age as predictor had a significant negative regression weight (second highest semi-partial correlatio$n$ = −0.25), indicating participants with higher age were expected to have less burnout scores, and age contributed high unique variance to the model (see Table 1). Having other family members in the US (semi-partial correlatio$n$ = 0.047), number of years of stay in the US (semi-partial correlatio$n$ = 0.01), and MGLQ (semi-partial correlatio$n$ = 0.136) did not contribute significantly to the model (see Table 1). Based on the findings of the full model, we developed a reduced model (see Table 2) for greater

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TABLE 1 Regression coefficients for the full model predicting burnout scores.

Predictor	B	95% CI	β	t	p
MSPSS	−0.189	[−0.279, −0.099]	−0.394	−4.157	0.000*
Age	−0.175	[−0.297, −0.052]	−0.362	−2.828	0.006*
MGLQ	0.078	[−0.022, 0.179]	0.146	1.541	0.126
US years	0.060	[−0.046, 0.167]	0.146	1.121	0.265
Family in US	0.930	[−2.521, 4.380]	0.050	0.534	0.594

Note: $R^2 = 0.22$ ($n = 106$), *$p < 0.01$, CI—confidence interval for *B*.

TABLE 2 Regression coefficients for the reduced model predicting burnout scores

Predictor	*B*	95% CI	β	*t*	*p*
MSPSS	−0.200	[−0.287, −0.112]	−0.414	−4.503	0.000*
Age	−0.153	[−0.242, −0.065]	−0.317	−3.446	0.001*

Note: $R^2 = 0.196$ ($n = 107$), *$p < 0.01$, CI—confidence interval for *B*.

parsimony that included MSPSS and age as predictors for burnout, F (2, 104) = 12.64, $p < 0.001$, which accounted for 19.6% variance in the burnout ($R^2 = 0.196$; adjusted $R^2 = 0.18$).

DISCUSSION

The reduced regression model suggests that age and social support (MSPSS) are predictors for burnout. In particular, higher age was associated with less burnout. Our results align with literature that describes a correlation of age and levels of burnout among mental health clinicians, immigrants, and non-immigrants alike. Gómez-Urquiza et al. (2017) found in a meta-analysis of 51 publications from health sciences and psychology that younger adult populations experience higher levels of burnout. Similarly, Marchand et al. (2018) found that symptoms of burnout vary according to the life stage of the worker. Workers were experiencing higher levels of burnout until the age of 30, experienced less burnout from age 30 to 55, and experienced higher levels after 55.

Higher levels of perceived social support also yielded lower levels of burnout. While the literature typically points to difficulties the overall immigrant population experiences when finding community after immigrating to the United States (Herrero et al., 2011), participants in this study indicated that they have community and/or felt supported. However, on average, participants in this study had been in the U.S for an average of 27.2 years, which supports research that found length of time as a variable in community formation (Kearns & Whitley, 2015). This study did not have a large enough sample of participants who migrated later in life, or who have been in the U.S for only a brief amount of time. Of note, despite social support being a significant predictor for burnout, having family in the United States had no impact on the level of burnout.

Another finding that begs attention is participants' number of years of stay in the US and their age. Because of the average age participants have stayed in the US (27.2 years), and a high correlation between participant age and the number of years they have been in the U.S (r = 0.70), one could deduce that most participants in the present study migrated to the U.S at a young age, completed their studies here, and have remained here ever since. Because of the high correlation between age and number of years of stay in the US, the latter did not make significant contributions to the model. However, in future studies, having participants who migrated to the US as adults or later stages of life may turn out to be a significant predictor for burnout.

Results from this study also highlighted that while our literature review and our data might have shown that migratory grief and loss is positively correlated with burnout, and it showed a positive correlation with burnout ($r = 0.20$), its unique contribution was limited. Despite its positive correlation with burnout, its unique contribution to the model was not significant because of low semi-partial correlation with burnout (sr = 0.136; Semi partial correlation refers to the unique relationship between an independent and a dependent variable and it does not include variance in the dependent variable explained by other independent variables).There can be a multitude of reasons that explain this finding, one being that the experience and expression of grief in general, and migratory grief and loss in particular might present differently among immigrants. The term "disenfranchised grief", coined by Stroebe and Schut (2010) is used to describe grief that is

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not recognized or validated by self or society, noting that the immigrant population may experience this type of grief. Immigrants may struggle with expressing their grief openly and freely, due to social and cultural factors, such as discrimination, language barriers, and cultural differences (Berger et al., 2004; Casado et al., 2010), which could explain why that grief did not impact their professional experience. Another reason that could explain these findings comes from the literature on volunteer work and helping professions, that repeatedly highlight that engaging in work that helps others is associated with higher levels of mental health, and could contribute to coping with grief and loss (Schwartz et al., 2003). A final potential reason for this finding might be that migratory grief and loss are not factors encountered by all immigrants. Some may experience grief and loss in the migration process depending on the circumstances of their immigration (Berger et al., 2004), whereas others may find relief in leaving tenuous environments in a home nation. Ultimately, these findings highlight that while the experiences of grief, loss, and trauma are known among immigrant populations, little is known about the relationship between grief and burnout among immigrant mental health professionals.

Finally, another key finding was that despite participants being in the U.S for an average of 27.2 years, results yielded a high score of migratory grief. This could highlight that the implications of migratory grief do not diminish with time. It is also important to highlight that the backdrop of this study were socio-political events that created high demand for mental health services in the United States. Such events included the COVID-19 pandemic, political shifts with a rise in white nationalism, anti-immigrant sentiments and incidents of racial violence in the United States, and economic challenges in various communities which likely influenced participant experiences. Those cultural variables, as well as the increased grief and trauma that has been on the rise as a result of COVID-19, could play a role in amplifying the migratory grief reported by participants.

IMPLICATIONS

It's critical to examine the implications of these findings using the ecological systems framework introduced earlier. As demonstrated in our findings, the intersection of multiple variables impact and shape the experiences of immigrant clinicians. Those variables intersect with the individual experience, the micro and the macrosystem, as it encompasses systems of support, cultural expectations and expressions of grief and connection to broader community. In training programs, mentorship assignments with both faculty and peer-mentors, culturally and language inclusive departmental social events, and departmental promotion of community events could help immigrant mental health professionals in training increase social support and find community connections. Increased support during training creates a foundation for success in mitigating post-migration stressors. Furthermore, programs should not assume that all immigrants have shared experiences. Thus, training programs should seek to provide individualized support and interventions that best meet the specific needs of the student. Training programs should also have intentional and early conversations with immigrant-identifying students on how to pursue support seeking behaviors, support systems, and self-care.

Post-training, colleagues, supervisors, and consultants of immigrant mental health professionals could model support-seeking behaviors that will mitigate burnout. Advocacy for increased access to culturally relevant services, language-inclusive supervision, and awareness of the needs of mental health professionals that identify as immigrants. Finally, promotion of mentorship and leadership to encourage a sense of belonging and purpose in the immigrant mental health professional's community. Across both training and post-training programs, it is necessary that faculty, mentors, and supervisors familiarize themselves with the unique concerns that immigrant-identifying trainees and supervisees face in order to center critical conversations about their needs. As it pertains to migratory grief, it's critical that supervisors allow space for an exploration of migratory grief, particularly for those who may have immigrated more recently. Taking note of variables such as social support and migratory grief when having conversations around self-care and burnout can signal to the individual that their unique immigration stories can inevitably impact their levels of burnout in this field.

FURTHER RESEARCH

Further research is needed to discern what types of support are helpful for immigrant mental health professionals. A qualitative inquiry asking what types of support systems have been the most helpful could help increase the knowledge of what types of services are needed in the community. Furthermore, an in-depth exploration of immigrant migratory grief and the variables that may limit or amplify it is necessary in order to identify mechanisms to mitigate its impact on a training and professional level. Additionally, a study that examines the ways in which migratory grief manifests in mental health professionals is critical to deepen our understanding of culturally relevant expressions of that grief. This could also offer insight into how

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immigrants perceive their grief, their experiences with disenfranchised grief and the ways in which their micro and macrosystems might make sense of that grief.

Age, as a variable in this study, yielded interesting results that impacted the trajectory of the analysis. This highlights that an inquiry regarding the specific role that age plays among immigrants in terms of their grief, quality of life, professional life and social support is critical. Identifying what age groups might be most impacted by higher levels of grief and burnout might allow for more targeted interventions among this group. Interventions can come in the form of culturally responsive clinical supervision that can integrate these findings in their work. As of yet, limited research is available that investigates the effects of culturally and linguistically relevant supervision for immigrant mental health professionals, if it increases perceived social support and decreases burnout.

Finally and of note, in recruiting participants for the current study, researchers contact all licensed mental health professionals regardless of immigrant status. We received multiple responses from mental health professionals who did not identify as immigrants yet expressed offense at the suggestion they were immigrants. As such, it might be critical to conduct further research on the mental health community's perception of both immigrants and immigrant clinicians. Finding from this research may help to inform the impact the professional community can have on the immigrant clinician's experiences.

LIMITATIONS

The study was conducted via online survey. While researchers sought an inclusive national sample, it was challenging to access the immigrant mental health professionals' population. Considering social stigma and fear of discrimination, potential participants may have been apprehensive to complete the survey even if they met the study criteria. There were many respondents to the survey that did not meet study criteria and thus had to be excluded from the sample. There were many participants that responded to the research request and inquired about how data would be used and the confidentiality of the survey before participating in the survey. Surveys which inquire about unpopular social attitudes, for example racism or discrimination, may have outcomes distorted by social desirability bias (Krumpal, 2013). Methods for combating the influence of this bias included survey design which protects confidentiality of respondents and assured responsible data storage and sharing procedures (Singer & Gray, 1995).

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CONFLICT OF INTEREST

The authors have no competing interests to declare.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

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