When Reunification Isn't Enough: Addressing the Limitations of Family Therapy for Transnational Families

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Introduction

For many families separated through immigration, reunification is not always a smooth return to normal; for many, it is a complex, confusing and fragmented process (Barros-Lane et al., 2022). Driven by improved economic opportunities resulting from globalization, migration has resulted in extended parent-child separation and the creation of transnational families (Bryceson, 2022). Transnational families refer to those separated across borders, but still maintaining a shared sense of unity and "familyhood" (Bryceson & Vuorela, 2002). Family separation has been shown to have negative effects on both those who leave and those who are left behind (Larrinaga-Bidegain et al., 2024; Ivlevs et al., 2019), as one youth recalls:

> *When we arrived to the airport and saw our mom, I hugged her and everything, but he [my brother] did not know her. My mom was crying, and she told him,"I'm your mother" and he said, "No," because he called his grandmother Mom.* (Barros- Lane et al., 2022, p. 7)

Conventional knowledge then imposes that reunification is a happy ending to separation. However, as the quote shows, this is not always the case. For many transnational families, reunion can mark new separations, exacerbate existing relational ruptures, and even create new challenges (Shaw, 2022). The Immigration and Refugee Protection Act (Department of Justice [Canada], 2025a) describes family reunification as the process of protecting the reunification of a foreign national with a Canadian citizen or permanent resident through the family class migration pathway.

In Alberta, Canada, mainstream family therapy models are not well-equipped to address reunified transnational families, as mental health is often viewed through a biomedical lens that depends on a chronic-disease-management framework (Office of the Auditor General of Alberta

[OAGA], 2022). Mental health biomedical models are culturally lacking for a vast group of marginalized people in Alberta, including newcomers and racialized groups (Alberta Association of Immigrant Serving Agencies [AAISA], 2017; Salami et al., 2019). Based on Statistics Canada's 2022 census, immigrants to Alberta come mainly from the Philippines, India, and Nigeria, with significant numbers also from China, Pakistan, and Syria. According to Immigration, Refugees and Citizenship Canada (IRCC, 2024a), family reunification is a key part of Canada's immigration system. Since most newcomers are racialized, it's likely that most transnational families reunited in Alberta are also racialized. The lack of an integrated mental health system that is culturally appropriate for transnational families is a critical gap in mental health services in Alberta. This gap is concerning because, despite being unprepared, Premier Danielle Smith requested a continued increase in immigration quotas (Dyer, 2024), and Canada maintains a 22% family reunification rate of admission (IRCC, 2024a). Lack of therapeutic support for these families results in greater mental health challenges, leading to prolonged adjustment difficulties and causing barriers to integration (Svensson, 2024). Despite the emotional and relational difficulties faced by transnational families after reunification, Alberta lacks a structured integration of evidence-based family therapy models to support them. Without input from local practitioners, service agencies, and families, therapeutic interventions risk remaining culturally and contextually inadequate. Addressing these shortcomings in the literature gap is vital to developing responsive, effective, and equitable family therapy frameworks in the province.

To critically examine these intersecting and complex issues, I adopt a social construction theoretical lens. Social constructionism posits that our experiences, identities, and knowledge are not objective or fixed, but rather created and co-constructed through cultural discourse, social

interaction, and language (Gergen, 1999, 2023). This lens is relevant to this capstone for the following reasons. First, this framework emphasizes a relational ontology that views identities, realities, and problems as created through interactions and relationships, rather than internal and isolated states. Second, discursive construction highlights how language creates reality and therefore shapes how these families are understood and treated. For example, using the term resilient to describe families may deter help-seeking as it can invalidate their distress and make them question the legitimacy of their struggles. Third, multiple truths recognize the lived realities of families that are typically outside the norm (e.g., nuclear families). Fourth, this framework posits that it is in dialogues, not diagnosis, wherein meaning shifts and healing begin, again making it more culturally accessible. Fifth, Gergen (2023) calls for relational responsibility by practicing reflexivity and culturally respectful therapeutic models and practices. Taken together, using a social constructionist approach enables me to critically examine Eurocentric assumptions (e.g., nuclear family) and biomedical perspectives (e.g., individual diagnosis) that dominate the literature, policy, and therapeutic practices concerning the mental well-being of reunified transnational families. In the following pages, I provide an overview of immigration, reunification and family therapy in Canada, before reviewing the literature on the psychosocial impacts and lived "realities" of separation, and finally, reviewing the literature on reunification outcomes. I then conclude by proposing a study that explores the lived realities of families moving to Canada.

Overview: Immigration, Reunification, and Family Therapy in Canada

Using Gergen's (1999, 2023) social constructionist lens, this section examines the policy and therapeutic contexts and limitations shaping transnational families, with a specific focus on Alberta. This is to demonstrate how these systems impact processes of separation

and reunification, laying the groundwork for the need for a culturally responsive therapeutic approach.

Canadian immigration context and pathways. Indigenous Peoples have inhabited the land now known as Canada for thousands of years, long before the arrival of French missionaries in the 17th century, and have since remained a nation of immigrants (Department of National Defence, 2018). Historically, immigration policies have been designed to settle the land, grow the population, provide labour, and boost the economy (Van Dyk, n.d.). Today, Canada has four categories of immigration pathways: Economic, Refugees and Protected Persons, Humanitarian, and Family Class (IRCC, 2024a). In 2023, Canada welcomed 471,808 immigrants, of whom 58% came from the economic category, which accounts for a 28% representation in the labour force (IRCC, 2024a). Gergen (1999, 2023) cautions us from thinking that Canada's immigration narrative is neutral, when in fact it is socially produced. By framing immigration as a pathway to Canada's economic growth, it positions migrants as labour assets rather than whole persons embedded in relationships and families (Gergen, 1999, 2023). To maximize human capital in Canada's immigration system, a points-based system was introduced, which rates individuals based on education, English fluency, age, and experience (IRCC, 2024a). These ideologies prioritize Western education and white careers as high-skilled, devaluing roles like caregiving often held by racialized migrants from the Global South (Oklikah et al., 2024).

In Canada, caregiver programs mainly involve educated, skilled racialized women labelled low-skilled (Oklikah et al., 2024), limiting their pathway to permanent residence and exposing them to exploitation (Picot & Crossman, 2022). These perceptions reflect a broader hierarchy, where low-skilled migrants are seen as eligible to work but socially inferior

(Oklikah et al., 2024). Such labels enable high-skilled migrants to undergo faster processing, while lower-skilled migrants often receive conditional status, effectively institutionalizing this division (Picot & Crossman, 2022). From a social constructionist perspective (Gergen, 1999, 2023), the points system is shaped by discourse that imposes a universal truth about who is skilled or worthy of entry, often reflecting Eurocentric measures of productivity, such as white-collar occupations, and erasing alternative truths and realities, and thereby marginalizing blue-collar occupations.

Family reunification. The inequities in immigration pathways set up the foundation for family separation and are further reflected in how family reunification transpires. According to the Canadian Museum of Immigration at Pier 21 (n.d.), family reunification in Canada was not a priority until the Immigration Act of 1976, which was a response to ongoing humanitarian complaints on family separation. This act created an "official" family class immigration category (Canadian Museum of Immigration at Pier 21, n.d.). Besides this pathway, a commitment to other (e.g. refugees and caregivers) family reunifications resulted in the Family Reunification Program (FRP) (IRCC, 2024a). According to Gergen (1999, 2023), Canada's family reunification labels, such as "official" and "commitment," are not neutral but are rooted in Eurocentric ideologies that uphold nuclear families and economic worth. Assigning "official" to the family class pathway, which is limited to permanent residents and Canadian citizens, is not random. It reflects a worldview that suggests only those who have demonstrated their economic value and worth to Canada through long-term settlement are more deserving and entitled to family reunification. Resulting in a waiting time of 10- 13 months to be reunified (IRCC, 2024b). Assigning "commitment" to the FRP signals benevolence and fairness, suggesting family reunification is a right and signalling the

government's moral responsibility. However, it conceals a selective access via a two-step immigration pathway. This pathway encourages economic migrants with precarious status (e.g., caregivers) to initially stay and work on a conditional basis, thereby qualifying for permanent residency before being eligible to apply for family reunification (Crossman et al., 2020). This process results in family separation lasting 3 to 8 years (CCR, n.d.-b). Essentially, it's a process to prove economic worth disguised as a commitment to family reunification.

Reunification is also affected by family definitions, which the Immigration and Refugee Protection Regulation (Department of Justice [Canada], 2025b) names as: spouses, dependents under 22, and common-law partners. This framing reflects a narrow, Western nuclear model. From a social constructionist perspective (Gergen, 1999), these definitions are shaped by dominant discourse, excluding culturally significant kinships like grandparents, siblings, or non-biological caregivers. Depicting nuclear families as standard marginalizes other family structures, especially in collectivist societies (Bélanger and Candiz, 2020). In extreme cases, narrow definitions may lead refugees to omit family members to avoid delays of up to 38 months (CCR, n.d.-a), which risks permanent separation (Phillimore, 2023). The family reunification process is biased, favouring some families and creating a hierarchy that leads to long separations. Until Canada allows families to migrate together, mental health support is essential. Thus, in the following subsection, I review the limitations of family therapy in Alberta to inform the development of suitable services for reunified transnational families.

The current family therapy landscape in Alberta. Having demonstrated the Canadian immigration pathways that lead to family separation and the problematic assumptions about family reunification. I now discuss the limitations of family therapy in

Alberta. The Public Health Agency of Canada (2024) highlights that current mental health treatments primarily adopt a biomedical perspective. Furthermore, Canadian therapeutic training emphasizes cognitive behavioural approaches because they are structured, evidence-based, and short-term (Klimkowski et al., 2024). These models often view distress as an individual, internal problem, which minimizes systemic, relational, and historical factors—such as family separation—risking framing responses as pathological (Fennig & Donov, 2019). Dominant biomedical models often emphasize cultural competence as a solution (Menon et al., 2024), but Danso (2018) criticizes this as shifting focus to an achievable checklist, while neglecting power structures and the creation of genuine cross-cultural practices. Simply culturally adapting cognitive behavioural therapy (CA-CBT) or translating forms (Menon et al., 2024) isn't enough. The assumption of CBT that changing families' negative patterns is enough (Ryum and Kazantzis, 2024) should be challenged. A truly culturally responsive approach reimagines frameworks to meet families' needs beyond just ticking boxes. Additionally, these models focus on diagnostic categories like adjustment disorder, not co-creating meaning through dialogue, which is culturally insensitive (Gergen, 1999, 2023). A study by Salami et al. (2019) found that medicalization deters immigrants, especially racialized and marginalized newcomers, from seeking therapy. Fear of stigma prevents them from pursuing help, as immigrants and refugees often see their distress as linked to faith crises, evil spirits, or personal weakness (Salami et al., 2019). A framework prioritizing client lived experience and multiple truths, promoting co-creation of meaning, is essential.

Access to mental health services in Alberta also poses a significant barrier. Publicly funded therapy is often short-term, limited, and primarily focused on individual therapy

(Alberta Health Services [AHS], 2024), which may not be suitable for complex relational issues faced by reunified families. According to Salami et al. (2019), the shortage of multilingual practitioners limits access, and financial constraints prevent many from affording private therapy, especially when priorities are settlement and basic needs (Salami et al., 2019). It is telling that mental health institutions favour clients who speak the dominant language, can pay for treatment, and can express distress in recognized ways. As a result, AAISA (2017) reports that families often use immigrant-serving agencies for settlement needs like employment, interpreters, case management, cultural brokers, and counselling. These agencies act as flexible, one-stop shops suited to language, culture, transportation, and time constraints. However, services are stretched thin, and counselling offers are limited since the main priority is settlement (AAISA, 2017). While they offer promising, culturally appropriate approaches suitable for reunified families, underfunding and an emphasis on biomedical models (Public Health Agency of Canada, 2024) hinder their effectiveness.

Overall, Gergen's (1999, 2023) social constructionist approach would critique Alberta's therapeutic landscape for lacking relational responsibility, placing the onus on families to adapt rather than creating culturally responsive services. The absence of responsive frameworks that capture alternative ways of healing reflects and reinforces a narrow Eurocentric understanding of what transnational families experience through family separation and reunification. Therefore, in the next section, I discuss the literature on the psychosocial lived realities of these families. By doing so, I reinforce that lived realities are shaped by relational, discursive, and social forces often overlooked in dominant biomedical models and need to be integrated into the development of culturally responsive models for these families (Gergen, 1999, 2023).

Psychosocial impacts of separation

The literature on the psychosocial impacts of family separation among transnational families often adopts a biomedical perspective, such as Ivlevs et al. (2019), who found increased depression and stress among left-behind family members. While useful, Gergen (1999, 2023) notes that it ignores culturally sensitive realities such as how separation, loss, and resilience are co-constructed within families and shaped by policies, migration, and community factors. Thus, in the following pages, I highlight the limitations of the biomedical literature by drawing on the social realities of families' lived experiences.

Left behind children (LBC). A systematic review of thirty studies found that children left behind in their families' home country due to migration experience higher emotional distress (such as depression and anxiety), behavioural issues (like conduct problems), and social challenges (including isolation and bullying) (Antia et al., 2020). The review primarily relied on cross-sectional studies, with only two being longitudinal and seven employing mixed methods. While the authors provide valuable insights into the mental health outcomes of LBC, their heavy reliance on quantitative cross-sectional studies promotes a generalized view of these children's mental health. This narrow focus reflects biomedical perspectives that locate problems within the individual and downplay the relational, systemic, and lived experiences of these children. Additionally, quantitative studies on LBC use the Strengths and Difficulties Questionnaire (SDQ) for its high reliability and validity (Antia et al., 2020). Studies do indicate this, especially among European countries (Husky et al., 2020). However, it is essential to note that its performance is less satisfactory in other regions, especially among non-English speaking populations and refugees (Essex, 2019). As such, quantitative studies favouring the SDQ overlook the Eurocentric assumptions it's based on (such as

whiteness) and ignore the complex lived realities of children from backgrounds of migration, trauma, and discrimination.

Another issue with LBC literature is that most research focuses on adults' perspectives, such as left-behind parents and teachers, overlooking children's own experiences and meaning-making (Liang et al., 2023). This is concerning, as Račaitė et al. (2024) found that adults often underestimate the distress of these children. Studies that prioritize LBC's voices are rare; one I found observed that it was the shifting of family responsibilities, negative social labelling by peers, and fracturing of parental emotional bonds that resulted in a spectrum of adverse emotions and experiences for these children (Fauk et al., 2024). Such results hint at Gergen's (1999, 2023) relational co-construction of realities. In summary, the current literature that privileges a biomedical perspective assumes that the psychosocial experiences of LBC are individual, can be diagnosed, measured through surveys, and narrated by adults. All these approaches downplay and overlook the relational, systemic, and discriminatory experiences of LBC that influence their meaning-making processes, coping strategies, and mental health, which are essential in a therapeutic setting.

Left behind spouse and parent. Most of the literature I encountered on the psychosocial impacts on left-behind spouses and parents emphasizes women's emotional labour and caregiving roles, with little attention given to male participation (e.g., father and grandfather). Both quantitative and qualitative studies indicate significant depressive symptoms and emotional exhaustion among left-behind grandmothers (Lee et al., 2023; Marchetti-Mercer et al., 2020). In a study by Rai et al. (2023), higher depressive symptoms in left-behind wives were associated with weak social support. Possibly, because left-behind wives shoulder the bulk of the emotional labour required to sustain a long-distance marriage,

often while suppressing their struggles (Chávez et al., 2021). To the best of my knowledge, I have found no peer-reviewed study from the last ten years that specifically addresses the mental health of left-behind males when women migrate. In studies that mention males, their experiences are not the focus but are usually combined with family experiences. For example, a study on transnational marriages showed that fathers feel shame due to role conflict and the inability to act as a "provider" (Acedera & Yeoh, 2020). Similarly, a study on transnational families found that men (such as in-laws and spouses) experience frustrations related to family tensions caused by migration (Escrig-Pinol et al., 2023). In both studies, there is limited information on men's experiences, highlighting a significant gap in research on the psychosocial impacts on left-behind males (e.g., fathers, spouses).

Most of the studies mentioned earlier also overwhelmingly narrate women's stories of loss, loneliness, and hardships. Although these findings are valuable, they only tell a single narrative, which minimizes and ignores the variability that exists across different contexts. For example, multiple authors demonstrate autonomy, resilience, and empowerment among women whose husbands migrate, despite social scrutiny and emotional burdens (Ghimire et al., 2021; Koirala, 2023). Overemphasis on adversity while ignoring experiences of resilience, autonomy, and empowerment reduces individuals to a diagnosis (Gergen, 1999). Gergen (1999, 2023) cautions us that an overemphasis on the gendered experiences of women and the near absence of studies on left behind men reinforces dominant Eurocentric discourse that assigns emotional burden, sacrifice and caregiving to femininity. This discourse constructs women as natural carers and men as absent or peripheral in nurturing roles, even when this is not the case. Through this discourse, knowledge is socially produced wherein gendered stereotypes are sustained and specific experiences (e.g. father) are marginalized (Gergen,

1999, 2023). This limitation in the literature underscores the need for a study that incorporates the voices of every family member to develop a culturally responsive family therapeutic model.

Migrating parents. The literature on parents who migrate without their children is predominantly qualitative, with limited quantitative data. In the qualitative studies, authors emphasize anxiety and powerlessness due to the ambiguity and uncertainty of reuniting with parents, negotiating work-family balance, relational stress, grief, and negotiating changing family dynamics (Larrinaga-Bidegain et al., 2024; Miaci and Seri, 2025; Escrig-Pinol et al., 2023). I could not find a peer-reviewed, quantitative study from the past five years on the psychosocial outcomes of migrating parents. From Gergen's (1999, 2003) social constructionist perspective, this absence is not coincidental. As noted by Larrinaga-Bidegain et al. (2024), dominant migration discourse depicts migrant parents, especially mothers, as self-sacrificing providers. Consequently, separation is viewed as a noble act to secure their family's future. A social constructionist would see the "self-sacrificing" discourse functioning as a moral economy that upholds endurance and hides explicit signs of anxiety, depression, or trauma because they would contradict the idealized image of resilience that supports public opinion and migration policies (Gergen, 1999, 2023). Validating certain truths enhances the image of the self-sacrificing provider and downplays systemic factors such as labour market inequities and precarious migration routes that compel separation.

According to Pettrachin and Abdou (2024), the lack of quantitative studies on migrant parents may also unintentionally weaken advocacy for systemic change, as quantitative data rooted in a biomedical perspective remains the preferred choice for decision makers, making it a powerful influence on policy and practice changes. Failing to produce quantitative

accounts risks leaving policymakers without the types of evidence they readily accept (Pettrachin & Abdou, 2024). An integration of both is necessary to capture the multiple truths of distress for this group, where measurable outcomes are given meaning through the lived experiences of migrant parents. This framing of the psychosocial implications of immigration among parents who migrate without their families directly influences therapy. When mental health systems internalize the sacrificing migrant parent, the focus remains on affirming resilience and teaching coping skills, rather than addressing relational ruptures and structural barriers. A culturally responsive framework should create space for migrant parents to express not only their strengths but also their ambivalence and grievances.

To summarize the social lived realities of immigration, it is clear that separation can cause significant psychosocial problems. Although more socially oriented research is now being conducted, essential voices and issues are still being excluded from these discussions, such as the lived experiences of children and fathers, and the validation of migrant parents' experiences through diagnosis. These lived experiences and voices are critical in the development of effective interventions for the very real damage and hardship that ignoring them likely causes. At the same time, although it is often implied that reunification is the end of transnational families' psychological distress, this is not the case. Effective interventions also need to consider the persistence and emergence of psychological distress upon reunification. As a result, I now examine the creation and persistence of challenges faced by transnational families post-reunification.

Reunification Outcomes

As discussed in the previous section, family separation caused by migration leads to lasting emotional, relational, and systemic effects that impact family dynamics even before

arrival. This section explores how these issues continue and can even worsen after reunification through the exploration of persisting psychological distress because lived experiences are not addressed, issues related to attachment and identity disruptions, and pressures contributed by social and institutional acculturation.

Persisting psychological distress because lived realities not addressed. Convenient knowledge frames family reunification as a joyous and reparative endpoint to family separation. Longitudinal studies like Löbel and Jacobsen (2021) support this assumption in their findings of improvement in depression and anxiety symptoms among refugees who reunited with a family member. This biomedical model emphasizes measurable symptom decline and assumes a linear process of health improvement. However, reunification does not always resolve existing mental health issues. As shown through a longitudinal study by Hvidtfeldt et al. (2022), continued psychological distress (post-traumatic stress disorder) persists past reunification, and symptom decline is also not a linear process. In fact, Löbel and Jacobsen (2021) discovered that the initial symptom decline they found plateaued after migrant family members reunited with their first family member, indicating the complexity of symptom reduction upon reunification.

Although both authors indicate that distress persists even after reunification, they both conceptualize it primarily as a diagnosis, effectively locating distress within individuals rather than within relational and discursive contexts (Gergen 1999, 2023). While both authors mention the precariousness of immigration systems, they do so as a backdrop rather than as co-constructors of lived experiences. This limitation is significant because reunification is not an individual experience, but a familial one, and it needs to be understood as such. Individualizing reunification is a limitation in the literature, as well as in therapy, as it centers

healing on an individual and misses the mark on relational repair. A culturally responsive approach requires consideration of treatment for the entire family.

Attachment and identity disruptions. Long-term separation of family members, as shown in the previous section, often weakens emotional bonds between parents, children and spouses, and introduces role confusion in families. A study by Shuang et al. (2019) found that migrant and left behind children showcase higher insecure attachment styles and a higher likelihood of depression as a result. Gergen (1999, 2023) cautions us against treating Eurocentric notions of depression and attachment as if they are universal, stagnant and internal, and ignoring the relational and meaning-making process of participants. Although Shuang et al. (2019) provide a general overview of attachment and mental disorder, which has its place, it lacks context and process, making it unhelpful in practice, in my opinion. To supplement this, we can look at other authors who note that complicated grief, mistrust, discomfort with affection, ambivalence, and emotional distance are shown to get triggered upon reunification (Shaw, 2022; Abranches & Jaber, 2025; Fernández-Sánchez, 2025), making reconnecting challenging for these families. Attachment strain and emotional distance become even more complex when infidelity occurs between spouses (Fernandez-Sanchez, 2025). Conversely, children's experiences of strained emotional bonds are further challenged in blended families (e.g., remarriage) and with new siblings born in the receiving country (Tungohan, 2020; Barros-Lane et al, 2022). Additionally, the involvement of extended non-nuclear family members, such as grandparents, adds to this complexity, as it can either strengthen or complicate family cohesion upon reunification (Shaw, 2022; Escrig-Pinol et al., 2023).

Role confusion that can sometimes exist during separation also has the potential to worsen family strain as children and parents adapt to new dynamics. Older children who assume parental roles often struggle to respect their parents' authority after having to manage parenting responsibilities themselves, and parents struggle to assert their authority (Barros-Lane et al., 2022). Grandparents who raised grandchildren may find it challenging to transfer parental roles, straining relationships with both their children and grandchildren (Dolbin-MacNab et al., 2021). Migration also shifts masculinity ideals and gets aggravated upon reunification as men adopt new roles, like caregivers, and adapt to cultural differences about gender equality (Sowad & Lafrance, 2024). Reunification then requires family members to renegotiate authority and relational boundaries. For parents, this means reasserting parental roles and reconstructing gender roles between spouses. For older children, this means adapting to no longer being the primary caregiver or decision-maker. This consideration needs to be incorporated for culturally responsive family therapy for reunified families.

Social and institutional acculturation. Social and institutional pressures, combined with unresolved distress from migration histories, can cause ongoing distress. Reunified families face a “dual burden' of adapting to institutions (e.g., work, schools, healthcare) and cultural norms (e.g., nuclear families), while processing traumas from family separation (Chaudry et al., 2021). Adapting to institutions is made difficult due to discrimination, like racism, and systemic inequities (e.g. income gaps), which affect identity and mental health access (Lerias, 2025). The lack of government and community support, especially for the most vulnerable immigrants (e.g. refugees), makes this more challenging for families (Sim et al., 2023). For example, lack of support for language acquisition leads to acculturation stress in immigrants and has been shown as a social barrier to access to institutions, such as mental

health (Salami et al., 2019). Verdaguer et al. (2023) demonstrate that immigrants with perceived lower acculturation experiences increased distress, especially when navigating unfamiliar spaces and cultural expectations. This distress has been shown to intensify when added to pre-existing emotional wounds from family separation (Verdaguer et al.,2023). For example, Barros- Lane et al. (2022) found that parent-child relational wounds from separation get reopened while executing institutional adaptation (e.g., helping children integrate into schooling). Parent-child acculturation gaps in particular result in family conflict and youth maladjustment (Leite et al., 2022).

Unlike families who migrate together and share the same adaptation process, reunified families merge from separate adaptation timelines. Family members who reunify often feel like strangers due to different migration and adaptation histories (Abranches & Jaber, 2025). These simultaneous pressures trigger pre-existing, fragmented emotional bonds, creating additional stress. Biomedical models often see reunification experiences as individual, universal, and fragmented. From a social constructionist perspective (Gergen, 1999, 2023), these distresses are co-created within unequal systems that require multiple institutional and family adjustments. I examined the post-reunification psychosocial impacts on transnational families, showing that the effects of separation persist and new ones emerge. The biomedical approach, which individualizes issues, overlooks relational, migratory, cultural, and systemic factors shaping family distress. To improve family therapy approaches for these families, I now introduce my methods section.

Method

My study's thematic narrative qualitative method aims to explore the lived experiences of transnational families in Alberta who have reunited after extended separation and participated in

counselling. A narrative inquiry is used to collect contextualized, rich, and participant-led stories from multiple family members. Involving participants with multiple relational roles preserves the integrity of each story, aligns with the need for multiple truths, and enables thematic comparisons (Riessman, 2008; Gergen, 1999). Thematic narrative analysis is employed due to its ability to identify deeper, more complex and realistic patterns of meaning within and across participants' narratives through collaborative meaning-making with researchers (Clandinin, 2013). Therefore, meaning from experiences is shaped through interactions between family members and researchers (Clandinin, 2013). Understood through a social constructionist lens, the generation of data in my study happens through diverse collaborative interviews, wherein participants guide the storytelling process, and multiple truths are acknowledged (Gergen, 1999; Clandinin, 2013). Data analysis encompasses linking broader social and institutional discourses (e.g., immigration) with themes from the interviews to amplify the intersections between lived experiences and systemic structures, examining narratives of how family members construct their own versions of themselves within cultural and systemic contexts.

Participants. Participants include family members residing in Alberta who have been separated and reunited within a minimum of 1 year and who have participated in counselling within the past three years. Families may have entered Canada through different migration pathways: refugee, economic pathway, and two-step immigration (e.g. caregivers). Families who have not experienced separation before reunification are excluded. A purposive sampling method (Creswell & Poth, 2018) is used to recruit families that meet the criteria, supplemented by snowball sampling through community networks. Recruitment will be supported by partnerships with settlement agencies offering counselling, as well as community and cultural organizations, along with word-of-mouth from other participants. For ethics, I will primarily abide by Tri-

Council Policy Statement (Canadian Institutes of Health Research [CIHR], Natural Sciences and Engineering Research Council of Canada [NSERC], & Social Sciences and Humanities Research Council of Canada [SSHRC], 2022) and the College of Alberta Psychologists' ([CAP], 2022) ethical guidelines. All recruitment materials and the consent process will be adapted linguistically as necessary (CIHR, NSERC, & SSHRC, 2022). CAP's (2022) ethical guidelines are followed in ensuring that informed consent is obtained from each participant and assent from minor participants. Confidentiality will be maintained throughout and within family narratives, as some stories may include sensitive disclosures about migration histories, legal status, and family dynamics (CIHR, NSERC, & SSHRC, 2022; CAP, 2022).

Data collection and analysis. A semi-structured in-depth interview design is used with questions inspired by narrative inquiry principles (Riessman, 2008; Clandinin, 2013) and a social constructionist stance (Gergen, 1999). This design is appropriate as it fits a social constructionist approach, which allows exploration of how families construct and interpret their lived realities of separation, reunification, and counselling experiences within the intersection of broader cultural and social contexts. As such, following Riessman's (2008) approach, interview questions and probes are guided by open-ended prompts that allow participants to tell their stories in their own way and with their own words. Through this thoughtful development of prompts and probes, participants are encouraged to share their stories before, during, and after separation, as well as their experiences with counselling (Riessman, 2008). Interviews will last 60-90 minutes and will be conducted either in person or via video conferencing, with interpreters available if necessary. Participants are given the option to either do interviews separately or together (in consideration for minors who might want their parents/guardians present) (CAP, 2022). Interviews will be audio-recorded and transcribed, while reflexive field notes are maintained to document

researchers' reflections. Transcripts will be reviewed alongside audio recordings to check accuracy (Creswell & Poth, 2018; CAP, 2022).

A thematic narrative analysis (Riessman, 2008) is employed to identify patterns of meaning, as it avoids fragmenting and limiting narratives into codes, thereby preserving the sequence and process of events. Data analysis will begin with a within-case analysis, in which family members' accounts are read and key themes are identified. Next, an across-case comparison is done to compare narratives across different families (Riessman, 2008). Interpretation of narratives is conducted through a social constructionist lens, wherein language, broader contexts (e.g., migration experiences), and multiple realities are privileged (Gergen, 1999). To ensure the trustworthiness of the analysis, I will employ reflexivity, triangulation, peer debriefing, and thick descriptions (Creswell & Poth, 2018). To safeguard the safety of participants, interview debriefs, access to mental health practitioners, and mental health resources are made available (CIHR, NSERC, & SSHRC, 2022; CAP, 2022).

Data storage. All data will be stored in accordance with ethics guidelines for human participants (CAP, 2022). Under CAP's (2022) code and Creswell and Poth (2018) guidelines, audio recordings, transcripts, and notes will be kept in encrypted, password-protected digital folders on a secure server accessible only to researchers. Any physical notes will be stored in the researcher's private office in a locked cabinet. Participants will be assigned pseudonyms, and all identifying information will be removed or altered to ensure confidentiality. Consent forms will be stored separately and retained only for the period required by the institution, after which they will be securely destroyed. Audio files will be deleted once transcripts have been verified. Professional interpreters, bound by confidentiality, will handle any translations (CAP, 2022; Creswell and Poth, 2018).

Risks, benefits and limitations. Abiding by the Tri- Council Policy Statement, participants contributing to my study may risk emotional distress, discomfort among family members, and confidentiality risks. To minimize risks, participants will be reminded during the confidentiality interview and debrief that they can pause or withdraw at any point in time without consequence. To reduce family discomfort, participants are given the choice to interview in the format they want, either alone or with a family member. Care will also be taken not to disclose members' statements without explicit consent given. To minimize the risks of sensitive information disclosure to those with precarious status, strict confidentiality measures will be upheld, and no identifiable information will be shared with third parties (CIHR, NSERC, & SSHRC, 2022). Participants in my study benefit from opportunities to reflect on their journey, contribute to knowledge by sharing their stories, and support advocacy efforts to change the landscape of counselling services and drive policy and practice changes (Riessman, 2008).

My study has several limitations to acknowledge. First, as it is a qualitative study, the findings are not generalizable (Riesman, 2008). Second, differences in counselling settings (e.g., settlement services, faith-based, school-based) may capture participant experiences that are not directly comparable. Third, while efforts are made to ensure the interview process is safe, the sensitive nature of the topic may cause participants to withhold information, which could limit the findings. Fourth, language and interpretation might affect the accuracy of the narratives, although steps are taken to maintain the participant's voice. Fifth, as a researcher, my own bias, cultural background, migration experience, education, and training may influence how I engage with my study (e.g., interpreting narratives), despite using reflexive and peer-debrief strategies to mitigate this (Riessman, 2008; Berger, 2015).

Reflexivity

I acknowledge that I am not a neutral participant in my study, and that my background, values, and training shape the relationships I form with participants, the questions I ask, and the interpretations I make (Finlay, 2002). This reflexivity statement outlines my positionality and the steps I will take to ensure transparency throughout my study. I identify as a racialized Filipina-Canadian woman shaped by three generations of family separation and living within two cultural frameworks of collectivism and individualism. These intersections inform my understanding of family, relational responsibility, structural inequities, gender, and migration. This background helps me approach participants and their stories with respect, cultural humility, and reciprocity. My social position as a Canadian citizen who arrived in this country as a permanent resident with my immediate family together, along with my graduate education, provides me with certain privileges that may influence my relationship with participants. I am aware of and attentive to how power operates in the research space, especially with those experiencing precarious immigration status and still separated from some family members.

Additionally, my professional background is shaped by the tension between my lived experiences within the community (non-profit and community builder) and my formal training, which is rooted in a biomedical understanding of mental health and family life. This dual positioning presents both challenges and opportunities. On one hand, my insider knowledge (Berger, 2015) enables me to recognize complexity in a participant's account that might be invisible to an outsider. However, it can also bring in assumptions and blind spots that require careful reflection on my part. At the same time, my biomedical training may lead me towards symptom-focused, individualized interpretations (Berger, 2015). I often find myself navigating both perspectives professionally, which influences how I listen, be present, interpret, and present the stories shared with me (Riessman, 2008). To address these risks, I plan to diligently engage

in reflexive journaling after each interview, debrief and seek feedback from my peers and supervisors, and ground myself in my social constructionist lens (Finlay, 2008).

Conclusion

This capstone set out to examine the gap in culturally and contextually responsive family therapy frameworks for reunified transnational families in Alberta. The goal was to show how these limitations hinder fair and effective care for families dealing with the complex effects of long-term separation, settlement stress, and changing family dynamics. Using a social constructionist perspective (Gergen, 1999), my study examined how knowledge, identities, and therapy practices are influenced by relationships, cultural contexts, and the language used in policies and professional discussions. In the literature review, this was done by examining the intersection of Canadian immigration policy, the psychosocial impacts of separation and reunification across family members, and the limitations of Alberta's therapeutic landscape. Additionally, through a social constructionist lens, I explored how discourse shapes which families are prioritized for reunification and how language impacts mental health seeking and support. Research on transnational families has shown that long-term separation takes a significant emotional toll and leads to complex relationship issues after reunification (Ivlevs et al., 2019; Barros- Lane et al., 2022). These issues can be especially tough when families face additional challenges like finding work, securing housing, and navigating unfamiliar social systems (Chaudry et al., 2021). The critiques in my literature review highlighted a lack of therapeutic models that are sensitive to local needs and cultural differences and can effectively address these interconnected challenges. The findings stress the urgent need for therapeutic approaches that are relationship-based and grounded in local realities that include migratory histories and acculturation stresses.

My interest in reunified transnational families and the lack of culturally responsive, appropriate family therapeutic services made me open to many learnings throughout writing this capstone. By exploring diverse literature and narratives, I've come to understand that the challenges faced by transnational families after reunification are rarely linear and can't be solved by models that focus on individual adjustment over systemic and relational change. Applying a social constructionist approach helped me see how the definitions and assumptions that shape therapy are not neutral, but are influenced by cultural, institutional, and political contexts. My personal experience with family separation and migration has shaped my awareness of the tensions families face during reunification. This lived experience has made me more perceptive to how therapy can either reinforce dominant cultural norms or create space for multiple truths to coexist. Admittedly, this capstone surfaced deep grief, loss, and disenchantment as I read and reflected through heartbreaking narratives of separation and fragmented bonds. However, it also strengthened my belief in the power of community, as mine held and uplifted me through this journey. Lastly, this capstone highlighted for me how therapeutic practices can unintentionally reinforce systemic inequalities, and how deeply embedded it is in my own academic background and counselling training. As I conclude this project, I am more committed than ever to incorporating critical reflection into both research and practice, making sure the voices of those directly affected stay at the forefront.

Recommendations

I recommend that mental health practitioners focus on migratory histories, relational perspectives, and acculturation stress when working with reunified families. Practitioners should develop family therapeutic models that address the relational, cultural, and systemic realities of individuals lived experiences, rather than modifying existing generic models. Policymakers

should aim to expand their understanding of what constitutes family, remove barriers that prolong family separation, and reduce limitations that increase acculturation stress. Policies should promote collaboration between settlement agencies, mental health providers, and community organizations to ensure holistic and culturally appropriate service delivery. Further research, particularly longitudinal studies on the relational development of reunified transnational families, is necessary. It is also important to explore differences between therapeutic approaches rooted in social constructionism and conventional methods to support further the development of appropriate family therapeutic models for reunified transnational families.

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