

Running Head: NON-LATINA/O CLINICIANS PROVIDING SERVICES IN SPANISH

EXPERIENCE OF NON-LATINA/O
MENTAL HEALTH CLINICIANS
PROVIDING SERVICES IN SPANISH

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ABSTRACT

This study explored the training and experience of 12 bilingual non-Latina/o mental health providers working with Spanish-speaking clients. Participants included 8 psychologists, 2 social workers, and 2 clinical psychology doctoral candidates with a minimum of one and a half years of experience providing Spanish-language services. The present study explored clinicians' methods of developing competency providing clinical services in Spanish and their experience working with Spanish-speaking clients.

Interviews were analyzed using elements of grounded theory, constant comparison and memo-writing, to reveal common themes and concepts. Key themes included: lack of formal training to provide services in Spanish; little if any institutional support for Spanish-speaking clinicians; increased energy required when working in Spanish; a sense of isolation; and the importance of flexibility, genuineness, and openness when engaging with Spanish-speaking clients. The scarcity of Spanish-speaking clinicians, particularly supervisors, was found to exacerbate the challenges faced by Spanish-speaking clinicians due to less training and fewer opportunities for consultation. The complexities of providing clinical services to Spanish monolingual and bilingual clients requires significant effort to attend to linguistic factors such as code-switching. Participants recommended training regarding Latin American history and culture, as well as courses on therapy in Spanish, and language-focused classes to assist in developing linguistic and cultural proficiency. Recommendations include increased hiring of both Spanish-speaking clinicians and Spanish-speaking support staff in clinics; need for training programs to provide Spanish-language learning resources, supervision, and training materials; and development of a clearinghouse of Spanish-language clinical forms to

increase accuracy and availability of Spanish language forms. Development of a professional network connecting Spanish-speaking clinicians in the US would provide much needed opportunities for consultation and reflection on the experience of providing clinical services in Spanish. Most important for clinicians is cultivating an openness to learn about oneself, one's clients, and, when uncertain about a linguistic or cultural exchange, to seek greater understanding through dialogue. This study further illustrates the significant need for increased support for Spanish-speaking clinicians throughout the mental health field, including training programs and mental health clinics.

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TABLE OF CONTENTS

ABSTRACT	ii
ACKNOWLEDGEMENTS	iv
TABLE OF CONTENTS	v
LIST OF TABLES	viii
Chapter I: Introduction to the Study	1
Purpose.....	1
Rationale	1
Chapter II: Literature Review	4
Background	4
Chapter III: Methods.....	30
Researcher and Support Team Background.....	30
Participants.....	31
Measures	32
Procedures.....	34
Data Analysis	36
Chapter IV: Results.....	39
Demographic Information.....	39
Learning Spanish	39
Experience Receiving Supervision of Spanish-speaking Clients	42
Clinician Experience Conducting Therapy in Spanish	56
Issues of Identity Impacting Service Provision	75
Navigating Boundaries.....	79

More casual and open with Spanish-speaking clients.....	80
Chapter V: Conflict with North American Views of Mental Health	83
Interrelationship of Mental Health and Supernatural Causes	83
Chapter VI: Clinician's Experience of Therapy	95
English-Speaking vs. Spanish-Speaking Clients	95
Chapter VII: Working with Spanish-English Bilingual Clients	105
Working with Mixed Bilingual Families	105
Chapter VIII: Organizational Context and Experiences	113
Reception by Latina/o Colleagues	113
Institutional-level Support	115
Chapter IX: Assessment of Spanish-speaking Clients.....	119
Clinician Experience Providing Assessment	119
Chapter X: Discussion, Recommendations, and Conclusion.....	124
Linguistic Competency Development.....	124
Clinical Competency Development	127
Limitations of the Present Study	137
Spanish Acquisition Focused Recommendations	139
Implications for Training Programs.....	141
Implications for non-Latina/o Clinicians	146
Implications for clinics that work with Spanish-speaking clients	148
Systems-Focused Recommendations.....	150
Implications for Future Research.....	152
Conclusion	153

References	157
APPENDIX A: Codebook	166
APPENDIX B: Interview Protocol	170
APPENDIX C: Demographic Questionnaire.....	174
APPENDIX D: Informed Consent Form	177
APPENDIX E: Advertisement Emailed to Potential Participants	181

LIST OF TABLES

Table 1: Methods of Managing Linguistic Difficulties.....	75
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Chapter I: Introduction to the Study

Purpose

The purpose of this study is to explore the experiences of non-Latina/o therapists providing psychotherapy and assessment to Spanish-speaking Latina/o clients. Research on therapist experience provides clarifying information about the challenges faced by non-Latina/o clinicians and how training may better address such obstacles to prepare non-Latina/o clinicians to provide clinical services in Spanish.

Rationale

Changing demographics of the United States of America. Given that the United States of America (US) is a country where English-speaking is the cultural norm, clinical psychologists within the US are all trained, whether explicitly or implicitly, to intervene with clients in English and to conduct therapy through the often-unacknowledged lens of US concepts of mental health and mental illness. Providing therapy and training future psychologists in English may not serve all of those in need. The US population is made up of many ethnic groups and recent immigrants. As many of these immigrants arrive from countries where English is not a primary language, language barriers exist for many people. Throughout the US, the Latina/o population is on the rise. According to the US Census, between 2000 and 2010, the Latina/o population grew by 43 percent while the non-Latina/o population grew by 5 percent. As of 2010, there were 50.5 million Latina/os in the United States, comprising 16 percent of the total population (Humes, Jones, Nicholas and Ramirez, 2011). Of the approximately 34.5 million Spanish-speaking people surveyed by the US Census Bureau American

Community Survey in 2007, 29.1% reported their English-speaking ability as ‘Not well’ or ‘Not at all’ (Shin & Kominski, 2010).

In 2001, the Surgeon General put out a report addressing the current state of mental health services for minorities in the US (Surgeon General’s Office, 2001). The Surgeon General reported that there are 29 Latina/o mental health professionals for every 100,000 Latina/os, while there are 173 White providers per 100,000 Whites (Manderscheid & Henderson, United States, 1998 as cited in Surgeon General’s Office, 2001). Latina/os are believed to account for nearly 65% of the population underserved by available mental health services in the US today; and yet there are not enough Latina/o psychologists. A survey sent out nationwide by the Surgeon General to a random sample of 596 licensed psychologists who are members of the APA indicated that only 1% of the psychologists surveyed self-identified as Latina/o (Williams & Kohout, 1999).

Addressing the disparity. Clearly, the mental health field and psychologists specifically must address the shortage of psychologists trained to provide care for Latina/os in the US. An ideal solution is to increase the number of psychologists available in the US with an emphasis on training Latina/o students. As demonstrated by Peters, Sawyer, Guzmán and Graziani (2014), the development and implementation of programs to support development of Latina/o bilingual mental health professionals is no small task, and one that requires far more than training Latina/o bilingual students in mental health positions.

As the distribution of psychologists suggests, there are simply not enough Latina/o clinicians available to even approach meeting the needs of the US Latina/o population, especially as the population of Latina/os in the US will grow faster than the

number of psychologists being trained each year. As such, it must be acknowledged that in addition to increasing the representation of Latina/os in psychology training programs, we must train both Latina/o and non-Latina/o psychologists to provide services to address the disparity between trained mental health professionals and Spanish-speaking clients. Given the high percentage of monolingual Spanish speakers among Latina/os in the US (Shin & Kominski, 2010), additional psychologists must be bilingual to adequately address the disparity in services. In order to increase the number of bilingual psychologists, it is imperative that programs explore and implement the best methods for preparing a trainee for bilingual therapy.

Chapter II: Literature Review

Background

Bilingualism and therapy. Therapy at its core is a process of communicating via language about our lives, including all the emotions, experiences, memories and thoughts we have related to what has happened, is happening, and will happen to us. In the United States, this process has developed through the lenses of the English language and predominantly European-American culture. As such, conducting therapy in multiple languages and working across cultures adds additional layers of complexity and requires us to re-examine nearly every facet of the experience.

Speaking Spanish in addition to, or instead of, English, may be reasonably expected to impact both client and clinician on a number of levels. Indeed, to be bilingual can refer to a range of abilities to communicate in more than one language. The earliest studies by Buxbaum (1949) and Greenson (1950) explored bilingualism through a psychoanalytic lens and predicted future research findings in their anecdotal observations. Specifically, Buxbaum and Greenson's case studies centered on the defensive use by patients of speaking in a second language.

Buxbaum's case studies focused on her German-English bilingual patients' speech patterns and willingness to speak their childhood language in relationship to intrapsychic conflicts. Attributing resolution of linguistic difficulties to resolution of conflict, she observed of one young woman that "a new language enabled her to detach herself from the psychic traumata of her childhood (Buxbaum, 1949)."

Soon after, Greenson further developed this concept of a bilingual client's language choice as a defensive mechanism. In his case study he explored the clinical

relevance of a German-English bilingual client's relative comfort speaking German, her more affectively charged language, over time. Greenson identified a client's choice of language in session as clinically relevant and a possible point of clinician intervention (1950). Greenson noted his patient's anxiety when encouraged to speak German to discuss a dream (which occurred in German). Greenson recalled that the patient explained her anxiety noting "I have the feeling that talking in German I shall have to remember something I wanted to forget." In Greenson's study one can begin to identify the potential impact of bilingualism on defensive functioning, memory, and emotional content. Greenson observed the patient had far more difficulty expressing obscene words in German than English as she felt that obscene words were "much easier to say" and "much 'cleaner' in English." Greenson proceeded to elucidate that the patient began to explore her distinctive self-image as language dependent noting "in German I am a scared, dirty child; in English I am a nervous, refined woman." Combining both his own observations and those of the patient, Greenson proffered a correlation between the influence of language of therapy sessions on the progress made and topics discussed. Furthermore, Greenson advocated a patient's use of German when he believed it would assist in overcoming resistances although he reported that by the end of therapy the patient's contributions appeared to be equivalent in either language.

These early studies and discussion of the interrelationship of a client's linguistic abilities and memory recall and use of a second language as a defensive mechanism (Buxbaum, 1949; Greenson, 1950) foretold future research into bilingualism and psychotherapy (Marcos, 1976a; Schrauf and Durazo-Arvizu, 2006). Both of the earliest studies of bilingualism and therapy tended to explore people who were portrayed as

equally bilingual (Buxbaum, 1949; Greenson, 1950) while the majority of bilingual speakers are not equally fluent in their two (or more) languages complicating the impact of bilingualism on clinical settings.

The first attempt to conduct a systematized study of the impact of bilingualism in clinical settings was conducted in 1973 through examination of Spanish-dominant bilingual patients with diagnoses of schizophrenia. Patients were rated as displaying significantly greater levels of psychopathology in English than when interviewed in Spanish (Marcos, Alpert, Urcuyo, and Kesselman, 1973a). In a follow-up paper examining the same dataset, Marcos, Urcuyo, Kesselmann, and Alpert (1973b) proposed that linguistic difficulties and increased cognitive load led to the behaviors interpreted as signs of psychopathology. Researchers noted that clinicians must be alert to their culturally-bound frame of reference when applying vocal cues of psychopathology to interviews of Spanish-dominant speakers, as cues such as silences may be related to secondary-language use. Additionally, possibly related to the cross-cultural nature of the situation, patients were found to be more emotionally withdrawn, more formal, and more concise when interviewed in English compared to when interviewed in Spanish (1973b).

Recognizing that a client speaking and living in multiple languages may complicate treatment, it has been recommended that clinicians recognize the potential differences in meanings of client's languages, and their relative ability to speak each language (Marcos, 1976b). The process of communication of emotions, memories, and even comfort in the therapy room may all be impacted by speaking in multiple languages. Indeed, earlier papers have recognized that the complications that may be caused by speaking multiple languages warrant special focus by the therapist (Marcos & Urcuyo,

1979). Marcos and Urcuyo noted that clients receiving therapy in their non-native language may not grasp certain nuances of therapist interventions due to cultural and linguistic differences.

The impact of bilingualism has been seen to be more widespread than simple communication difficulties. Based on clinical observations, Marcos, Eisma, and Guimon (1977) reported that some bilingual clients experienced themselves differently depending on the language in which they were communicating. Clients displayed more negative sense of self and other when communicating with therapists in their non-native language. This awareness and integration of language-dependent sense of self in therapy greatly expanded the clinical relevance of bilingualism. Although early thinking was that either language would suffice to explore such issues (Marcos, Eisma, & Guimon, 1977) thinking soon shifted to acknowledge the impact of experiencing therapy in a client's second language due to difficulties grasping nuance (Marcos & Urcuyo, 1979).

Emotion and language. Before examining therapeutic interventions in Spanish and cultural values of clients, it is important to recognize that communicating in one or more languages is distinct from monolingual English communication. Languages appear to be divided into three categories of words (abstract, concrete and emotion), yet words in the same conceptual category are not necessarily equivalent in meaning across languages (Altarriba & Bauer, 2004; Pavlenko, 2008).

While emotion has been conceived of as a universal concept in the recent history of psychology, studies of emotion words in Spanish and English suggest that emotion word memory differs between English and Spanish. Research by Grabois (1999) suggested that differences exist in the semantic representation of emotion words between

monolingual speakers of Spanish and English. Altarriba's (2003) study of Spanish-English bilinguals and emotion word recall suggested that Spanish emotion words when compared to English emotion words may represent a broader range of expression and may be more closely tied to specific contexts than their presumed English equivalents. The authors reported that these differences were not due to inherent characteristics of Spanish but a result of Spanish being the participants' first language. Clinicians must pay greater attention to determining a bilingual client's primary language rather than assume in which language a client will experience a broader emotional range as a result.

It is important to note that many emotion words were not included in the Altarriba study (2003) specifically because they lack word-to-word translations between English and Spanish thereby limiting any inferences to words with singular translations. Indeed, the presence of emotion words that represent partly or wholly different concepts determined by language is especially relevant with regard to bilingual people and not easily addressed by current models of bilingualism (Pavlenko, 2008).

Given the centrality of emotion to the psychotherapeutic process (Greenberg & Pascual-Leone, 2006) differences in language of emotionality may be of vital importance to bilingual clients and their therapists. By addressing the interconnectedness of bilingualism and emotions, and acknowledging potential loss of nuance in translating emotion words, psychologists providing therapy may gain greater insight into their own experience and that of their clients. By recognizing the possibility of differing understanding of emotional words clinicians may better identify and explore the impact of a client's culture and linguistic fluency on their emotional experience. Awareness of distinctions between emotion words in different languages may assist clinicians in

determining what language in which to conduct therapy, and anticipate possible miscommunication, whether conducting cross-cultural therapy in Spanish or English (Altarriba and Santiago-Rivera, 1994; Javier, 1990). Further exploration of clients' precise meaning rather than assuming that a direct translation is possible and accurate (Altarriba, 2003) has the potential to enrich the interaction between clients and clinicians.

Bilingual memory and language congruity. If emotion and language are understood to be two of the core pillars of therapy, then memory may be identified as a third key pillar. Autobiographical memory models have often included emotion encoded within them yet language was only recently found to be central to autobiographical memory in bilinguals. Five Spanish-English coordinate bilinguals were instructed to speak for 5 minutes on an interesting or dramatic personal experience in the language in which it took place. Then, after distractor tasks, they were asked to repeat the story in the other language. After analysis, participants were found to have provided significantly more vivid detail when telling the story in the same language in which the experience took place. Yet the small sample size ($n=5$) suggests a limited generalizability (Javier, Barroso, & Muñoz, 1993). In addition, the fact that subjects repeated the same story later on may suggest that the lack of detail is more related to repetition or memory issues than linguistic retrieval differences.

This interaction between language and memory is known as *language congruity*. *Language congruity* is a concept referring to the finding that memories are greater in detail and intensity when recounted in the language in which they were encoded than when told in another language. It is important to recognize that for coordinate bilinguals, a person who organizes their experience using two separate languages, the language of

encoding is not necessarily their primary language. One therapeutic implication of language congruity is that clients whose primary language is Spanish experience less affect when discussing memories encoded in Spanish when speaking in English (Marcos, 1976a).

While one might assume that decreased affective experience related to language congruity would be undesirable, language congruity has been accepted as therapeutically useful. Code-switching as a therapeutic technique was first alluded to by Greenson in 1950, recommended by Marcos and Alpert in 1976 and further elaborated upon by Pitta, Marcos and Alpert in 1978. While recounting a memory encoded in Spanish to a therapist in English would restrict a client's affective experience, that decrease in affective charge can be used by both client and therapist to maintain a more manageable level of affective arousal in session.

Bilingual memory and language specificity. Whereas language congruity relates to a client's recall of memories, language specificity refers to the language through which a client's memories are elicited. Language congruity regards the client's choice of language within a therapeutic interaction while language specificity has implications for the therapist's choice of language when eliciting a client's memories. Language specificity is the concept that memories are more easily elicited by the same language in which they were encoded. This suggests that if therapists address Spanish-English bilingual clients in English, they will be less likely to learn of experiences that occurred while speaking and thinking in Spanish (Marian & Kaushanskaya, 2004; Schrauf & Durazo-Arvizu, 2006). Indeed, this very fact was first noted by Buxbaum in 1949 who

reported that speaking to his German-English patient in German more effectively elicited her childhood memories which took place in German.

Language choice. Emotion words not only have varying meanings, they also elicit different levels of emotionality in speakers (Harris, 2004). Emotionality is defined in this context as “autonomic arousal elicited by particular languages or words...examined through changes in skin conductance response (SCR)...and through verbal and non-verbal behaviors and self-perceptions” (Pavlenko, 2008, p. 155).

Displaying and playing various emotional expressions including taboo words, reprimands, insults, and endearments, Harris (2004) explored emotional reactivity by measuring the responses of Spanish-English bilinguals who learned Spanish as their first language (L1). When presented in English (L2), reprimands reliably elicited less emotionality in people who learned English during their middle childhood or teen years. While this may support the common-sense hypothesis of L1 as more emotional, it has also been shown that early English learners displayed heightened SCRs to both English and Spanish taboo words, suggesting that learning both languages early on can lead to equal impact of emotion-laden words. It is important to note that Spanish-English bilinguals experience their primary language as more emotional than their secondary language, mediated by both age at acquisition and context (Harris, 2004).

These differences in emotionality have been shown to influence the communication choices of bilinguals in multiple domains (Pavlenko, 2008). When expressing intense affect such as anger, bilingual speakers reported making language use decisions based on their desired level of affective involvement. Some bilingual writers reported intentionally writing in their L2, English, in order to distance themselves from

the traumatic affect that they may experience were they to write in their native languages (Pavlenko, 2005). On the other hand, bilinguals expressing anger have been shown to often revert to their L1 when arguing with others even when the other person does not speak the same language. This appears to be due to a sense that expressing negative affect in L1 is seen as more satisfying (Dewaele, 2006).

This phenomenon of *code-switching* is of significance for clinicians as the language choice of a client provides important cues to the therapist along with possible intervention points. First recognized as clinically significant by Buxbaum in 1949, code-switching by bilingual clients was next discussed in 1950 by Greenson. Greenson referenced Buxbaum's findings and concluded that a patient's use of their secondary language served to repress memories and feelings that would be more accessible speaking their primary language of childhood. In his own case study, Greenson affirmed the clinical significance of a client's language choice ranging from emotionality, to defensive mechanisms and including examples of client identity being related to language of speech. Not only does Greenson note his patient found obscene words to be "much easier to say and 'cleaner' in English," but his patient also expressed distinct identity differences based on her language choice noting "In German I am a scared, dirty child; in English I am a nervous, refined woman." Greenson noted that while initially willing to speak in English or German, he found her resistance increased when discussing obscenities, as well as when discussing a dream in German. He also observed that speaking in German, her primary language, enabled her to revisit and more fully process conflicts from her childhood. Greenson expressed support for clinical use of supporting the client in speaking her primary language when meeting resistance in a patient's

secondary language, English in this case. This case study provides anecdotal support for later findings regarding greater emotionality of words in a client's primary language (Pavlenko, 2008) as well as language congruity, as the patient recalled greater detail when discussing childhood dreams in her primary language.

When clients choose to speak in their second language, they may be trying to reduce their emotional contact with the topic being discussed, such as the writers previously mentioned. More importantly, they may be intentionally impeding their ability to recall memories of certain events (Marcos, 1976a; Marcos and Alpert, 1976; Pitta, Marcos and Alpert, 1978).

In 2002, Santiago-Rivera and Altarriba reviewed the literature on the use of language with Spanish-English speaking clients and recommended that greater attention be paid to client's use of language and linguistic history. In 2009, Verdinelli & Biever, (2009a) explored the experience of Spanish-English bilingual psychotherapists learning and using Spanish personally and professionally. Both clinicians who grew up speaking Spanish and those who learned Spanish later in life reported that both clients and clinicians switched between English and Spanish in session. A subset of the participants further noted this as clinically relevant while a smaller group learned to identify their clients' reason for switching languages and monitor and guide code-switching when useful in session. As noted by the authors in their paper (2009a), the participants' therapeutic use of code-switching whether to increase or decrease their clients' affective arousal is consistent with past literature on the topic (e.g., Altarriba & Santiago-Rivera, 1994; Clauss, 1998; Marcos, 1976a, 1976b; Pitta, Marcos, & Alpert, 1978; Santiago-Rivera & Altarriba, 2002).

Training to become a bilingual psychologist. Programs to train bicultural, bilingual psychologists have begun to appear (Pacific University-Oregon, Our Lady of the Lake University, Massachusetts School of Professional Psychology) and yet the field is still far from able to meet the needs of the Spanish-speaking population of the United States. Despite two decades having elapsed since a review of progress in the field (Bernal & Castro, 1994) suggested that the field had far to go in training sufficient numbers of bicultural, bilingual psychologists, bilingual/bicultural providers continue to be a scarce resource. Indeed, it is now widely accepted that there is a critical need for a significant increase in the number of bilingual/bicultural mental health providers for the Latina/o population of the US (Guarnaccia, Martinez, Acosta, 2002; Rios-Eliz et al, 2005; Surgeon General's Office, 2001).

Currently there are some clinicians who provide services in Spanish yet no statistics are available so it is difficult to estimate the number of Spanish-speaking clinicians presently. A recent survey conducted by the APA and the Surgeon General did not even assess the languages used professionally by the psychologists surveyed (Williams & Kohout, 1999). In order to learn from those clinicians' experiences, Castaño, Biever, Gonzalez, and Anderson (2007) addressed difficulties faced by bilingual therapists who have become competent in providing Spanish language therapy services despite being trained in psychotherapy in programs in English.

Castaño et al. (2007) compiled data from surveys returned by 127 self-identified providers of Spanish language therapy. Participants were recruited through the APA's Office of Ethnic Minority Affairs Job Bank Database and various professional electronic distribution lists including the APA practice directorate and training directors of

counseling, clinical and school psychology programs. It is not possible to determine the level of Spanish proficiency of those providers as the study utilized self-identified providers of Spanish language mental health services. No demographic breakdown of respondents was included beyond linguistic skills, creating ambiguities regarding the providers' racial and ethnic identity that readers may gloss over with assumptions. The 95% of the respondents included in the study that learned Spanish in the home as children are not identified as of Latina/o descent; although the authors may have expected readers to assume this it is not clear. Without additional data, it cannot be determined if the remaining 5% of participants who did not learn Spanish at home were non-Latina/o Spanish speakers, or Latina/o persons who were not taught Spanish at home. Without demographic information, it is impossible to determine which psychologists-in-training may benefit from the study's findings, whether Latina/o therapists, non-Latina/o therapists, or all of the above. In order to best train bilingual therapists, future studies could be improved by providing in-depth demographic information on the participants. Additionally, while more difficult to conduct, future research directly engaging with Spanish-speaking clients about their experiences in treatment with different therapists would be invaluable to future training and treatment.

The survey addressed issues of language fluency in reading, writing, and speech, as well as the degree of concern surrounding fluency. Other questions addressed the therapists' opinions of their training experiences in developing bilingual competency, and perceived need for more bilingual therapists. They were asked to describe how they learned Spanish, any formal training received, what services they provided in Spanish, and advice on how to prepare to provide bilingual services. While supervision was the

most common form of training received, it was considered ‘very useful’ by only 40% of respondents, one of the least useful methods compared to other training experiences.

Conversely, coursework in language and cultural variables in assessment and psychotherapy and coursework in bilingual assessment were considered ‘very useful’ by 66% and 68% of respondents, respectively. Participants most often suggested that competency could be improved by receiving bilingual or Spanish-only supervision of services, especially during externship placements. The difficulty with this idea is, of course, the aforementioned scarcity of Spanish speaking mental health professionals.

The authors (Castaño et al, 2007) emphasized that based on the study’s findings and their professional experience, formal training for therapists intending to provide bilingual services should include: courses on how to apply and translate interventions and theories in Spanish, more common cultural knowledge of issues and differences within Latina/o subgroups, and professional use of spoken and written Spanish. The 2007 study provides an empirical basis for developing training for bilingual therapists. While past papers on the topic have provided qualitative data based on authors’ experience (Marcos et al, 1973a, 1973b; Marcos 1976a, 1976b; Verdinelli & Biever, 2009a, 2009b), the study by Castaño et al (2007) provided a wider range of experience from which training recommendations may be developed.

As the aforementioned research (Castaño et al, 2007; Verdinelli & Biever, 2009a, 2009b) has suggested, there are relatively few bilingual psychotherapists, and even fewer therapists specifically trained to provide services to bilingual or monolingual Spanish-speaking clients. While research has demonstrated that language plays a significant role in the clients’ experience and the impact of therapy, little research has been conducted on

the experience and impact of bilingualism on psychotherapists. Additionally, research on assessment of Spanish-speaking clients remains in the earlier stages of development.

Assessment of Spanish-speaking clients. As revealed in a national survey in 1997 (Echemendia, Diaz, Harris, Congett, and Puente, 1997), 82% of neuropsychologists in the US who worked with Hispanics reported that they felt inadequately prepared to provide services to Hispanic clients. Since this survey was conducted, attention and exploration of the issues regarding assessment of bilingual Hispanic clients has continued to increase. Unfortunately, even as increasingly more psychological measures are being developed in Spanish, it is important that clinicians not take for granted that the measure has been translated accurately. A number of Spanish language measures have been demonstrated to be inaccurately translated and improperly validated (Fortuny et al, 2005). Furthermore, as noted by Cofresi and Gorman (2004), the literature that exists regarding assessment of bilingual Latina/os continues to focus largely on issues of validity, and test bias.

While it is important that appropriate test selection be addressed, something that has been made significantly more possible thanks to the development of *Pruebas Publicadas en Español* (Schlueter, Carlson, Geisinger & Murphy, 2013), attention to the larger context of psychological assessment is also vital in proper assessment and evaluation of Spanish-speakers. The importance of addressing cultural issues in testing of monolingual and bilingual Spanish-speaking clients (Acevedo-Polakovich et al., 2007) requires that clinicians assess a client's linguistic background and ability as well as their immigration history for proper test selection. Without doing so, clients may be administered measures inappropriate to their linguistic ability, educational history, and

possibly assessed without recognition of all relevant stressors and factors impacting their apparent psychological functioning. Furthermore, it is important to acknowledge that assessment is not without implicit cultural values, and that the US approach to test-taking as an impersonal and time-sensitive interaction may clash with clients' cultural expectations of more interpersonally focused interactions, leading to negative impact on the client's performance on measures administered (Cofresi and Gorman, 2004).

Clinicians should assess clients' level of education and recognize that education in Latin America varies considerably and that years of education in Latin America cannot be presumed equivalent to years of education in the US. As a result, the impact of clients' level of education must be taken into consideration in test selection as well as interpretation of results (Judd et al, 2009).

Experience of bilingual psychologists. An early qualitative study on the issue of bilingual psychotherapy, Verdinelli & Biever (2009a) interviewed 13 Spanish-English bilingual psychotherapists, all of who identified as Latina/o. By comparing and contrasting the experience of both native Spanish speakers (born in a Spanish-speaking country), and heritage speakers of Spanish (those who were born in the US but learned Spanish at home) many themes and issues became readily apparent. Overarching themes common to both heritage and native speakers included training, supervision, the experience of being a bilingual therapist, using two languages in session, and therapists reporting differences in their experience whether working in Spanish or English. From the results of Verdinelli and Biever's study (2009a), three themes most relevant to future bilingual therapists were: training challenges, supervision challenges, and the use of two languages in session. Regarding input of the studied therapists on training and

supervision, native speakers discussed the importance of improving their English language skills. On the other hand, heritage speakers had a number of points, all of which can clearly apply to non-Latina/o bilingual trainees as well as heritage speakers. Participants focused on two areas, specific training for providing bilingual services, and development of professional language skills. These can serve as the framework for any current and future programs to train bilingual psychotherapists.

In order to provide better training for bilingual services, therapists recommended classes taught in Spanish as well as guest speakers. Going a step further they recommended being instructed on bilingualism *and* biculturalism (Verdinelli & Biever, 2009a). This distinction between linguistics and culture is a key point to be incorporated in hiring and training. While clinicians are often assumed to possess bicultural knowledge due to speaking Spanish, it is important to recognize that speaking Spanish does not innately provide cultural competence to work with Spanish-speaking clients (Castaño et al, 2007; Schwartz, Rodríguez, Santiago-Rivera, Arredondo, & Field, 2010). It is important that clinical approaches to predominantly European English-speaking clients not simply be translated into Spanish (Smith, Rodríguez, & Bernal, 2011). While one model of training clinicians for Spanish language clinical work has been put forth (Biever et al, 2002) there has not yet been any evaluation to determine its efficacy at accomplishing the stated goals.

Challenges faced by heritage speakers in providing therapy centered on the differences in Spanish spoken by their clients: dialect, speed, intonation, and colloquialisms all complicated the matter. Heritage speakers noted difficulty translating Spanish into English in their minds during sessions. The issue of code-switching was a

primary issue for the heritage speakers but not the native Spanish speakers. Heritage speakers noted that understanding and tracking their clients' code-switching was difficult for them, although they also noted that clients reported stressful events in the language in which they occurred, consistent with the concept of language specificity (Pavlenko, 2008; see also Verdinelli & Biever, 2009a).

Most important to note is that all 13 participants in the study received graduate training in English in the US and learned to provide services to Spanish-speaking clients through trial and error. As the current state of training programs provides clinicians with 'trial and error' training, in order to comply with Section 2.01b of the APA Ethics Code (American Psychological Association, 2010) training programs must be updated.

Where scientific or professional knowledge in the discipline of psychology establishes that an understanding of factors associated with age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language or socioeconomic status is essential for effective implementation of their services or research, psychologists have or obtain the training, experience, consultation or supervision necessary to ensure the competence of their services, or they make appropriate referrals, except as provided in Standard 2.02, Providing Services in Emergencies. (American Psychological Association, 2010)

Yet while it is important to support the competent practice of clinicians, it cannot be done without also acknowledging the "critical need for more bilingual/bicultural mental health professionals" and the related lack of training opportunities (Guarnaccia, Martinez, and Acosta, 2002) for such professionals. Given the rapid growth of the

Latina/o portion of the US population, clinicians providing services to Spanish-speaking Latina/o clients will continue to find themselves challenged to provide competent services without further training improvements. Despite many useful themes noted in the study (Verdinelli & Biever, 2009a), it is important to note that all of the psychotherapists studied were of Latina/o background, leaving the experience of non-Latina/o bilingual psychotherapists open to future research. Research that explores possible differences in experience among non-Latina/os who have learned Spanish through academic settings may clarify whether the differences between heritage speakers and native speakers also exist between heritage speakers and non-Hispanic Spanish speakers.

In addition to exploring language development and use, Verdinelli and Biever (2009b) conducted a study to explore the most common training experiences of bilingual therapists, namely, bilingual supervision. Researchers recruited 15 participants from a training program for Spanish-speaking mental health providers. Participants included eleven women and four men, including four non-Latina/o White participants and eleven Latina/o participants. Participants were divided into three separate focus groups, each meeting for approximately 2.5 hours. In order to gain as much useful data as possible, participants were allowed to discuss in either language (English or Spanish), and most switched languages at numerous points throughout the study. Questions were provided as prompts to generate discussion of the role and supervisory dynamics that language contributed in their supervision experiences as well as the participants' preferred method of supervision for Spanish-speaking clients. Responses were coded and analyzed afterward using an established approach to phenomenological analysis and multiple coders.

Reviewing themes, Verdinelli and Biever (2009b) found burdens on bilingual trainees related to working with Spanish-speaking clients to be the most prevalent issue. A lack of bilingual professionals and culturally competent professionals clearly impacted all aspects of their experience. The trainees reported additional work, due to few bilingual professionals, as well as the need to interpret, and educate other professionals around them. Without bilingual supervision, trainees found themselves feeling isolated and rejected due to issues of cultural sensitivity and lack of institutional support for themselves and their clients. Participants reported language-related concerns regarding themselves, observing in themselves and their clients' issues related to language specificity. Some participants noted concern that both their clients and themselves used code-switching to avoid intense affect at times in session and supervision.

Recently, attention has begun to turn toward more focused examinations of the use of code-switching by therapists when working with Spanish-English bilingual clients (Santiago-Rivera, Altarriba, Cragun, Poll, and Gonzalez-Miller, 2009). Santiago-Rivera et al. explored clinician use of code-switching in session as well as their understanding of the causes contributing to code-switching by clients in session. Code-switching by clinicians was noted to be used to increase ease of communication by clients when clinicians noted clients having difficulty expressing themselves due to limited English proficiency. Furthermore, clinicians code-switched to assist development of trust. Having the ability to switch languages was found to enhance the therapeutic process by increasing the ability to access clients' experiences and increase emotional expression of their clients. Therapists in the study reported switching languages at times to facilitate client understanding and to build trust with their clients. Clients were noted to switch

languages to discuss emotional content and increase understanding.

Future research should explore more fully the impact of these language-related concerns on therapist experience and their ability to competently provide services. Greater detail on the specific ways clinicians feel that their status as bilingual clinicians has led to concern and isolation may provide further support and suggestions to lay the groundwork for improved training of bilingual therapists and improvement of presently practicing bilingual clinicians.

The results of Santiago-Rivera et al's study (2009b) strengthen the principles and suggestions put forth by Castaño and others. The researchers astutely note that given the small number of non-Latina/o participants ($n=4$) the study would not be able to arrive at findings specific to non-Latina/o bilingual therapists. Future studies can address this issue by recruiting a larger and more balanced participant pool to enhance the potential findings. Verdinelli and Biever also note that participants were all self-selected as they had been at a training for providing bilingual therapy, which suggests their experience may not be representative of less motivated bilingual therapists.

Key concepts in bilingual/bicultural therapy. While studies addressing the issue of conducting therapy with Spanish-speaking clients and receiving supervision have begun to build a body of knowledge regarding gaps in current graduate training, very few have attempted to begin developing the training currently noted as lacking by studies (Castaño et al, 2007; Verdinelli & Biever, 2009a, 2009b). Miguel Gallardo (2012) has recently published a paper discussing techniques and concepts that can aid a therapist in conducting initial interviews with Latina/o clients. Referencing a mixed-methods study he conducted, Gallardo presented data from 27 therapists in response to the question

“What techniques/strategies do you implement to initially engage and build rapport with Latina/o clients?” Addressing a key failing of past studies, Gallardo started with a sample of 89 Latina/o mental health practitioners and then utilized abbreviated measures of acculturation and multicultural competence to focus on those clinicians who were bilingual and bicultural. Gallardo noted that in seeking to improve the quality of responses by determining “expertise” there are various confounds added, given the lack of a universally accepted measure to do so. At the same time, this focus on “expert” practitioners as opposed to any bilingual therapists illustrates progress and increasing standards for developing knowledge for working with Latina/o clients. Participants’ educational level, degree, age and gender were provided in the report, enabling a finer level of analysis than past research, although still limited given the moderate sample size. Themes that surfaced the most often included *personalismo* (defined as “an orientation where the person is always more important than the task at hand”) (Santiago-Rivera, Arredondo & Gallardo-Cooper, 2002), *respeto* (respect), language use, psychoeducation, *platica* (small talk), and therapist self-disclosure. Gallardo noted that these results are consistent with the past literature (2012) regarding multicultural therapy and working with Latina/o clients.

While language use did arise in the results, as in the past studies related to issues with bilingual therapy (Castaño et al, 2007; Verdinelli & Biever, 2009a, 2009b), it is vital to recognize that it was only one of many issues that the therapists mentioned as central to developing a therapeutic relationship. These issues emphasize the central role that increasing training specific to working with Latina/o s and availability of linguistically and culturally competent supervisors must play in meeting the needs of the increasing

Latina/o population of the United States. Concepts such as *personalismo*, *respeto*, *platica*, and increased therapist self-disclosure are unlikely to be understood or taken into consideration by English-speaking supervisors. Even when taking them into consideration, clinicians should recognize that all Spanish-speaking clients do not equally value the above concepts. The importance of understanding and respecting a client's ethnicity can have a significant impact on rapport, as well as treatment, and diagnosis especially when culturally-bound experiences of mental health are involved (Marcos, 1988).

Bicultural therapy as a dynamic process. Developing bicultural training must move beyond stereotypes and memorization of specific cultural concepts as previously discussed. We must recognize that culture includes language, ethnic identity, attitudes and views of mental illness, as well as shared values (Guarnaccia and Rodriguez, 1996). These are not static concepts but processes that impact both clients and therapists. Often unrecognized in the United States' mental health system, is that culture affects not only the languages we speak but also how we understand and treat mental illness.

In recent years, research has been conducted exploring the relationship between perceptions of depression and attitudes toward treatment among predominantly Mexican immigrants in the Midwest (Cabassa, Lester and Zayas, 2007). Cabassa, Lester and Zayas assessed the attitudes of 95 Hispanic patients in a primary care setting. The study explored participants' attitudes through presentation of vignettes of patients with symptoms of Major Depressive Disorder according to DSM-IV criteria. The study reported that patients largely ascribed depression to interpersonal and economic circumstances as opposed to internal causes such as chemical imbalances, biology, or

genetics. Additionally, patients identified depression as a combination of facing situational difficulties while lacking social support to help them cope. Assessment of patients' attitudes toward treatments for depression revealed that they held a slight preference for counseling over antidepressant medication and held doubts regarding the effectiveness of medication (Cabassa, Lester, and Zayas, 2007). Martinez Pincay and Guarnaccia (2007) conducted similar research, utilizing focus groups, exploring Latina/os' understanding of mental health, mental health treatment for depression, and barriers to care in the New York metropolitan region (Martinez Pincay & Guarnaccia, 2007). Martinez Pincay and Guarnaccia (2007) explored participants' perceptions of depression and mental health treatment through focus groups drawing from a range of settings (mental health agencies, social service agencies, schools, churches, etc.). Both studies determined that mental health providers need to more specifically incorporate the attitudes and perceptions of Latina/o immigrants into treatment and outreach. Specifically, Martinez Pincay and Guarnaccia demonstrated that Latinos are aware of depression and accurate when identifying it with a tendency to focus on emotional and physical symptoms equally rather than viewing somatic symptoms as secondary in contrast with the DSM-IV authors. Echoing Cabassa, Lester and Zayas' (2007) findings, participants viewed depression not as an illness but a result of social difficulties including loneliness and isolation from others. Martinez Pincay and Guarnaccia emphasized that Latina/os' view of depression as a consequence of life disruptions and interpersonal difficulties supports social interventions including therapy in that it provides a social context for processing their emotions and helping them rebuild their social supports. On the other hand, the authors note that medication contradicts Latina/os' views of

depression's causes by locating the source of depression as a "disorder" rather than a result of external circumstances. Additionally, medication risks submitting them to the mental health stigma of being *loco* (crazy) and being perceived as disabled. Most crucially, Martinez Pincay and Guarnaccia provided recommendations to improve the mental health treatment of Latina/os. They highlighted the need for increased time spent orienting Latina/os to the process of mental health treatment and the professional code of conduct therapists follow in the US given the distinct difference there is from the tradition relationship styles Latina/os typically have among friends and family. This added focus on orienting the clients to treatment, treatment norms, and goals of therapy is noted to contribute to increased *confianza* (trust) in the therapeutic relationship. By recognizing that it is not only clinicians, but also clients who have wisdom and knowledge to improve mental health services, these studies provide a direction for programs providing bicultural therapy.

Without properly understanding context and conceptualization of mental health of Spanish-speaking clients, providers often privilege their own cultural beliefs, devaluing clients' views even as they attempt to provide bicultural services (Guarnaccia and Rodriguez, 1996).

Directions for future research. Future research should address the issues of specific concepts involved in bilingual therapy, both linguistically and culturally. The evidence has mounted that there is a lack of bilingual therapists, bilingual supervisors, and bilingual training opportunities. Yet it is vital that in the push to meet the needs of Latina/o clients, the field remain focused on ensuring linguistic and cultural competence of those who provide bilingual therapeutic services. Furthermore, given the reality that

Latina/o clients will likely be treated by bilingual non-Latina/o White therapists as well as Latina/o therapists, it is imperative that more White therapists be included as participants in future studies on these issues. While the field has begun to address obstacles experienced by Latina/o Spanish-speaking therapists, the experience of non-Latina/o Spanish-speaking therapists remains an area to be explored. This dissertation aims to explore the experience of non-Latina/o Spanish-speaking therapists both related to their training and their clinical experiences. By doing so it is hoped that the Principal Investigator (PI) may incorporate the feedback and experiences of non-Latina/o therapists to offer recommendations to improve the training of non-Latina/o Spanish-speaking therapists as well as the daily practice of Spanish-speaking clinicians in the field.

Overview of literature. There exists a broad body of literature exploring bilingualism and its impact on clients in treatment. Yet the focus of research has only recently begun to focus on the impact of bilingualism in therapy on the clinician's experience and approaches to training such clinicians. While there are presently bilingual clinicians engaged in this work, research has shown that the majority of clinical psychology programs have not been preparing clinicians for work with clients' who do not speak English (Bernal & Castro, 1995).

Over the past ten years, studies regarding Spanish-English bilingual therapy have explored issues of supervision (Verdinelli & Biever, 2009b), clinicians' Spanish language development (Verdinelli & Biever, 2009a), and broader challenges of providing mental health services in Spanish (Castaño et al, 2007). These studies have broadened the body of knowledge regarding Spanish language psychotherapy and provided guidance for both clinicians and researchers. Yet studies have until recently included few, if any, non-

Latina/o clinicians. While the reason for this is unclear, this may be due to difficulty recruiting non-Latina/o bilingual clinicians as well as the belief that Latina/o clients are best served by Latina/o clinicians. Without such representation, it is impossible to know whether training programs aimed at Latina/o trainees will also address concerns of non-Latina/o trainees seeking to conduct therapy in Spanish.

This study seeks to explore the qualitative experience of non-Latina/o clinicians conducting Spanish-language therapy and their insights regarding useful training for bilingual clinicians. The study aims to gather qualitative data to guide development of training toward a higher level of care for Latina/o clients. Recommendations for future training will be developed based on the themes and concepts derived from the participant experiences and recommendations made by participants.

By expanding the focus of training from bilingualism and more recently biculturalism to encompass the intersection of language, culture, emotion, and clinical setting, training has the potential to raise the quality of care provided to Latina/o clients, while also supporting the training of an even greater pool of potential bilingual clinicians.

Chapter III: Methods

Researcher and Support Team Background

The research was primarily conducted by the primary investigator (PI) with assistance during the data analysis phase from a research team. The PI is an experienced clinician of European American Jewish descent who has provided bilingual therapy to Spanish-speaking clients. The PI has studied and practiced Spanish for 17 years. The course of Spanish language study included 10 years of formal learning in academic settings beginning in the 6th grade and informal study and continual practice in social settings for an additional 7 years. The PI has worked at three clinical sites where his responsibilities included conducting psychological evaluations and providing therapy to Spanish-speaking clients. He has provided individual therapy to monolingual and bilingual Spanish-speaking patients ranging in ages from 6 to 65 years old, group psychotherapy in Spanish, and worked with one Spanish-speaking couple providing couples therapy.

The research team consisted of a Doctoral Candidate in Clinical Psychology, who was also conducting qualitative research regarding clinicians' experience. This member of the team served as an initial coder for the first interview after which she consulted with the PI to develop an initial set of codes to apply to the following interviews (See Appendix A).

The other member of the research team transcribed 4 of the 12 interviews while the other 8 interviews were sent to a professional transcription company to be transcribed for purposes of expediency. After all interviews were transcribed, the PI reviewed each transcript and compared it to the audio recordings for accuracy.

Participants

Twelve therapists (9 women, 3 men) participated in this study, 11 who identify as European American and one therapist who identifies as British. The average age of participants was 42.92 years with participants' ages ranging from 27-67 years of age.

To be included in the study participants were required to have provided a minimum of one year of Spanish-language mental health services regardless of licensure-status, and raised in a home in which English was the primary language during their childhood. Clinicians who self-identified as Latina/o, had a parent from a Spanish-speaking country, or were raised in a Spanish-speaking household or culture were excluded from participating in the study.

Ten of twelve participants were licensed at the time of their participation. Two participants (25%) were social workers (1 MSSW and 1 LCSW), 6 participants (50%) were doctoral level clinical psychologists (5 PsyDs in clinical psychology, 1 PhD in clinical psychology), 2 participants (16%) were clinical psychology doctoral candidates in their final year of training, one participant (8.33%) was a licensed counseling psychologist with a PhD in counseling psychology (8.33%), and one participant was a forensic psychologist with a PhD in school psychology (8.33%).

Participants were asked to rate their Spanish-language ability on a number of dimensions (e.g., reading, writing, speaking). Participants were also asked to describe their Spanish-language education (duration, setting, and self-rating of proficiency). The mean length of time spent studying in an academic setting was 6.4 years, while five clinicians rated their proficiency level in Spanish as advanced, five clinicians rated

themselves as fluent in Spanish, one participant rated herself as near-native fluency, and one participant did not respond.

Interestingly, ratings of overall proficiency were lower than ratings of conversational proficiency. The range of self-ratings of overall proficiency ranged from Advanced to near Native-equivalency while the range of self-rating of conversational proficiency ranged from Advanced to Native-equivalent. When asked to rate their proficiency in reading and writing Spanish, the range of ratings broadened further to Intermediate to Native-equivalent. The participant who rated herself highest received the most education in Spanish, having attended one year of secondary school in a Spanish-speaking country.

Participants length of experience ranged from 1.5 years providing clinical services to Spanish speaking clients to over 30 years providing services to Spanish-speaking clients. The average length of time providing services to Spanish speaking clients was 8.67 years and the median length of time was 6 years. The average participant worked with a caseload of approximately 40% Spanish-speaking clients although the range was from 5-80% Spanish-speaking clients in participants' caseloads.

Measures

The measures employed in this study consisted of a demographic questionnaire and a semi-structured interview protocol. The demographic questionnaire was a modified version of a survey used in a study exploring clinicians providing therapy to Spanish-speaking clients (Castaño, Biever, González, & Anderson, 2007). Although the survey is not copyrighted, permission was obtained from Dr. Biever with attribution required, prior to modification and usage.

The questionnaire was provided to most of the participants prior to participating in the interview and then reviewed by the PI prior to interviewing each clinician, although due to complications three of the twelve participants completed the questionnaire after participating.

The questionnaire included questions asking participants their age, ethnic identity, gender, sexuality, professional license or training status, year of licensure, most recent Spanish-speaking client, and percent of their current caseload that consists of Spanish-speaking clients. Participants were also asked to rate their Spanish-language ability on a number of dimensions (e.g., reading, writing, speaking). Participants were also asked to describe their Spanish-language education (duration, setting, and self-rating of proficiency). Participants were also asked to report any training received on working with Spanish-speaking clients and their opinion of the utility of various training experiences for developing competency as a bilingual professional. Finally, all participants were asked to rate their perception of the need for bilingual, well-trained therapists.

This study focused on the use of a semi-structured interview protocol (See Appendix B) designed by the PI for the purposes of this study. The interview protocol was designed by the PI to facilitate exploration of participants' training to provide clinical services to Spanish-speaking clients and their experience of providing services in Spanish. The semi-structured interview focused on five key areas 1) training received to provide clinical services to Spanish speaking clients, 2) participants' experiences of conducting therapy in Spanish, 3) experiences working with Spanish-English bilingual clients 4) professional experiences and reception by others as a non-Latina/o Spanish-speaking clinician; and 5) training recommendations.

Each participant was asked the questions included in the guide, with additional prompts when necessary to encourage more complete responses. Given the semi-structured nature of the interview, in addition to the questions included in the protocol, the PI asked follow-up questions regarding topics and themes that arose in individual interviews. Furthermore, participants were provided time at the end of each interview to address any additional topics or themes they felt they wanted to discuss or expand upon beyond those raised by the PI.

Language of questionnaire and interview protocol. Both the questionnaire and the interview guide were written in English, although the interview was conducted predominantly in English for 11 of the 12 participants, one participant opted to begin the interview in Spanish and continue in Spanish for a significant portion of the interview to gain additional practice speaking Spanish. Throughout the interview participants were permitted to choose the language in which they communicated with the PI and to switch back and forth between English and Spanish as they wished.

Procedures

Given the lack of significant risk to participants, the PI submitted the research protocol and questions to the Rutgers University Institutional Review Board (IRB) and received approval under exempt status per 45 CFR 46, Category 2, as of June 19, 2013. Participants were recruited through an announcement made by the PI at the LPANJ annual conference in 2013. Participants were also recruited through a combined purposive sampling of alumni of the PI's graduate program via an advertisement emailed to alumni (see Appendix D) and snowball sampling of referrals from initial participants referring other qualified clinicians in the field.

All interested participants were emailed a brief overview of the study and the consent form to review prior to meeting with the PI. The consent form explained the purpose of the study, procedure of participation, risks and benefits of the study, and both confidentiality and limits to confidentiality. Participants were also provided with contact information for the PI and other individuals affiliated with the study. (See Appendix E). The consent form also informed participants that they could withdraw at any time during the interview and could also refuse to answer any questions they did not want to answer. Participant consent for audio recording was also obtained at the same time as their consent to participate in the study. Those participants interviewed via Skype were sent consent forms to sign via Hellosign.com or Docusign.com a method by which they were able to sign and initial a consent form prior to participating in the study. Skype interviews were scheduled prior to consent forms being signed but were not conducted until after receipt of confirmation that the forms had been signed.

Participants were met at an agreed upon location or if scheduling and geographic distance did not allow for an in-person meeting, participants were interviewed via Skype. During all interviews, participants were allowed to consume food or drink if they wished during the interview. Each participant was then interviewed by the PI using the Demographic Questionnaire and the Interview Guide (See Appendices B and C) developed by the PI. Prior to being interviewed each participant was assigned an identifying number to protect their identity. All interviews were audio-recorded to later be transcribed and reviewed. No identifying information was included with the study data. Each interview lasted approximately 2 hours.

Treatment of data. All consent forms and demographic questionnaires were initially scanned onto the PI's computer, stored as PDFs, and stored in a password-protected folder encrypted using the AES-256 encryption standard on a password-protected computer at the PI's residence. Those consent forms and demographic questionnaires that had been completed digitally were saved as PDFs and stored in a password-protected folder encrypted using the AES-256 encryption standard on the aforementioned computer.

Hard copies of the interview guides were labeled with the participants' ID numbers and stored in a locked cabinet to which only the PI had access. Four of the transcriptions were transcribed by a Doctoral level research assistant, assigned a numerical code, and stored in a password-protected file after which they were reviewed for accuracy by the PI and encrypted using the AES-256 encryption standard. The other 8 interviews were transcribed by a HIPAA-compliant professional transcription agency then reviewed by the PI for accuracy and encrypted using the AES-256 encryption standard. The PI determined that all study data will be destroyed three years after completion of this study.

Data Analysis

This study utilized semi-structured interviews. Data from the participants were analyzed through qualitative content analysis conducted by the PI using Nvivo 10 for Windows. In order to enhance the reliability of coding on subsequent interviews, during the initial round of coding, the PI and an additional independent rater coded the initial interview independently. During initial coding, responses were reviewed line-by-line and coded for the related interview prompt. These codes were then subdivided into themes

based on participant responses and other issues of relevance to provision of therapy in Spanish.

After coding the initial interview, the raters compared their coding and developed an initial code workbook (Appendix E). The workbook guided coding of subsequent interviews while being revised as new categories emerged from the data. After initial coding was completed, themes and categories developed over the process were further explored and analyzed by the PI for patterns, themes and categories relevant to non-Latina/o bilingual clinicians' experience and training. The concepts of constant comparative analysis and aspects of grounded theory per Charmaz (2006) were used throughout coding the transcripts. Grounded theory is an approach to qualitative data analysis first developed by Glaser and Strauss, elaborated upon by Strauss and Corbin (2008), and most recently revised through a social constructivist lens by Charmaz (2006). Grounded theory involves coding, memo-writing, and constant comparison, as well as theoretical sampling. The constant comparative method involves inductive coding of data, comparison of events with codes, events with other events, and codes with other codes to determine similarities and differences within the data. Through constant comparison, coding and memo-writing can be refined and further differentiated to aid in analysis. Along with the workbook, the PI engaged in reflective memo writing regarding concepts that required further clarification and refinement. At times, to gain added perspective, the independent rater was consulted on coding distinctions to reduce the likelihood of overly broad or overly specific codes. Theoretical sampling was not employed in the study given the narrow participant pool. Codes were compared to each other and to the text in order to confirm they were consistent and accurate descriptors of

the data. Coding of interviews utilized themes and issues of relevance in the interviews as the unit of analysis. “Experience conducting assessments in Spanish,” “experience conducting therapy in Spanish,” and “training recommendations” were three major top-level codes, as well as “competency development” which focused on how participants developed their skill at providing clinical services in Spanish. Another top-level code, “linguistic impact on service provision” encompassed codes including “methods of managing difficulties with language,” “code-switching,” and “difficulty with vocabulary” as examples (See Appendix A).

Chapter IV: Results

Demographic Information

Types of service provided. The participants (12) reported experience providing a range of services in Spanish. Most participants provide individual therapy in Spanish or have past experience doing so. Close to half of the participants provided couples and family therapy (5) in Spanish, and slightly over half (7) provided group therapy in Spanish. While not the focal point of the study, most participants (10) reported some degree of experience conducting psychological assessments in Spanish. Yet only two of those participants spend the majority of their time conducting psychological assessments.

Geographic origins of Spanish-speaking clients. Participants worked with clients from a range of countries and ethnicities, eleven regions in total. The countries and locations of origin of patients most commonly mentioned included: Mexico, Dominican Republic, Puerto Rico, Ecuador, Guatemala, Honduras, Colombia and El Salvador. Three countries of origin were mentioned by a single participant: Peru, Venezuela, and Uruguay.

Learning Spanish

Motivation. Participant motivation for learning Spanish ranged from the personal to professional. One quarter (3) of participants reported personal connections to Spanish-speakers as reason for learning Spanish and another quarter (3) of participants stated that a love of the Spanish language motivated them. Whether visiting an American friend who studied Spanish in Spain, working with a Mexican family, or personal interest in the Spanish language and related cultures, many participants identified it as a personally motivated choice. One third of the participants acknowledged social justice, often related

to their religious upbringing, as an underlying motivation of their work with Spanish-speaking and Latina/o clients. Some participants expressed early motivation to learn Spanish for the utility to future careers based on the influx of Spanish-speaking immigrants to the US.

Setting and method. The majority of participants (9) began learning Spanish in secondary school and continued to seek training as they got older although one participant began learning Spanish in elementary school. Six of the participants who began studying in secondary school continued their Spanish language studies in college, majoring in Spanish or a Spanish-related double major. Four participants reported taking post-secondary school coursework conducted in Spanish, three of whom attended one to two graduate-level classes in Spanish. One participant continued his Spanish education learning experience informally while working at a restaurant owned and run by an El Salvadoran family.

Two participants had significant gaps between learning Spanish and applying that knowledge in their professional life. One participant graduated college with a Spanish-related major, earned a master's degree in social work, and then did not utilize her Spanish or clinical skills for 17 years as she worked as a full-time mother taking care of her children until they both left for college. The other participant with a significant gap learned Spanish in secondary school (6th through 12th grades) and did not study further until 50 years old. She re-learned Spanish through a combination of language audio lessons, language software, college courses, Spanish language media consumption, and casual conversation, up to 30 hours/week.

Immersion experiences. Most participants (10) lived in a Spanish-speaking country at some point in their lives with eight of the participants who lived abroad doing so during college with a host family. One participant lived with a host family during high school for an entire school year. One quarter (3) of participants, all of whom attended the Latina/o Mental Health Program at the Massachusetts School for Professional Psychology (MSPP), lived abroad in Ecuador and Costa Rica as required by the program. While most participants studied abroad, only two participants worked while living in a Spanish-speaking country. Of the two participants who worked abroad, one worked in Ecuador for the Peace Corps while another worked in Mexico at a home and school for homeless children.

Maintaining Spanish abilities. Participants engaged in various activities to maintain and improve their Spanish abilities. Three quarters (9) of participants socialize with friends and coworkers in Spanish, occasionally code-switching between Spanish and English as part of their efforts to maintain their Spanish abilities. Half of all participants (6) listen to audiovisual media in Spanish to practice including movies, music, *telenovelas* (Spanish-language soap operas), language learning CDs (e.g. Pimsleur), audiobooks, smartphone apps (e.g., Duolingo), radio shows (WADO 1280AM), and audio magazines (e.g. Punto y Coma). Important to note as the majority of participants engage in regular activities to maintain their Spanish is that the range of activities and resources available to Spanish learners at the present time (books, audiobooks, movies, radio, television, software, and audio magazines) provides a form of media for everyone, regardless of whether they want to use materials specific to learning a language or simply engage with Spanish-language media.

Experience Receiving Supervision of Spanish-speaking Clients

A central and wide-ranging consequence of the scarcity of Spanish-speaking mental health professionals is a scarcity of Spanish-speaking supervisors. While half (6) of participants have received a mix of supervision from Spanish-speaking supervisors and English-speaking supervisors, the reality for trainees and clinicians is best expressed by the words of one participant:

The opportunity to get the supervision, to get the teaching and the training, especially by bilingual, bicultural supervisors is very slim and difficult to come by.

Experience receiving supervision from English-speaking clinicians. Nearly half of participants (5) have never received supervision by a Spanish-speaking supervisor, including an MSPP graduate. These participants received supervision from English-speaking supervisors with a range of results. This experience often leaves clinicians and trainees aware that they are lacking valuable feedback and input on their clinical work while also facing new challenges. One participant, trained over 30 years ago, noted:

Because I spoke Spanish, I was given all the Spanish-speaking kids to work with. Unfortunately, we had no Spanish-speaking supervisors at that time. So I was kind of learning on my own.

This experience of thirty years ago continues to be a reality today as participants trained recently continue to lack Spanish-speaking supervisors. This lack of supervision, including supervision from English-speaking clinicians, contributes to a sense of being ‘on their own’ with regards to cultural knowledge as well as linguistic knowledge.

I've been 'the person' that does the Spanish-speaking evaluations. So I just haven't had a more experienced clinician or someone who was, you know, a native speaker to bounce ideas off of, get feedback from, or supervision.

Another participant reported receiving supervision from an English-speaking supervisor in her first job working with Spanish-speaking clients:

I loved it but it was hard. It was definitely harder, and my supervisor wasn't Spanish-speaking, so I was lucky a good friend of mine is Puerto Rican, and so she actually guided me a lot.... to understand different cultures.

This experience of English-speaking supervisors often lacking cultural competence was noted by a number of participants. The experience of clinicians in many situations can be well summarized by one participant who described her training experience as a Spanish-speaking trainee.

You're often put in a position where you're working with Spanish-speaking patients, but your supervisor doesn't necessarily speak Spanish. And also, your supervisor isn't necessarily all that culturally attuned or aware to what might be going on for the individual patient.

As noted above, a number of participants recalled a lack of oversight, advice, and cultural competence of English-speaking supervisors:

[Regarding culturally sensitive assessment] - My supervisor wasn't really helping me with that either necessarily, because I wasn't really understanding the dynamics and she didn't really know to ask about the dynamics.

[Regarding lack of oversight in current job] I was thrown into it... You know, I'm in session and nobody's critiquing me.... I could just be making some mistakes that could be easily corrected....and again my supervisor wasn't Spanish-speaking.

Furthermore, the six participants who received supervision from Spanish-speaking supervisors had faced similar issues with English-speaking supervisors supervising Spanish-speaking cases. They reported lack of oversight of Spanish-speaking cases.

I don't find that my supervision has been very strong, in supervising those [Spanish-speaking] cases they're not videotaped, they're not audio recorded, there are no process notes. There could be much more done in that area to help me be a better Spanish-speaking clinician, because a lot of what I'm saying and reporting back to a non-Spanish-speaking supervisor, there are things that they're probably missing and I'm not aware of either. So I think that that's a real problem...in that the supervisors are not always available.

They also frequently felt isolated, without relevant preparation or supervision in training-level positions.

At the high school, I was being supervised by an English-speaking person. I was the only Spanish-speaking person on that staff, as a student I was it. And again I was in a very under-resourced high school... so there wasn't particular cultural training there. A lot of it is just throw you in, figure it out.

Standing out from the experience of other participants, one participant received assessment training and supervision from a monolingual English-speaking clinician and was placed in a position of assessing Spanish-speaking clients. When asked about the linguistic challenges conducting assessments in Spanish, she recalled “I don’t think I had any help in that. She was very sensitive to the issues but she didn’t speak Spanish herself.” This participant implied that her supervisor was culturally competent yet a lack of linguistic ability suggests that even an otherwise culturally competent supervisor would have limited ability to adequately supervise a trainee conducting assessments. While some issues may be taken into account regardless of language ability, as assessments are inherently a language-centric activity, a clinician unable to speak the language would be unable to fully assess the adequacy and results of the assessment (Aguirre et al, 2005). Echoing the experience of working in situations without a Spanish-speaking supervisor, one participant noted finding herself in such a situation on her first day at a crisis intervention program.

It was my first day of work and my supervisor said ...we had a Spanish-speaking family come in that they’d just learned that their 13-year-old daughter was pregnant...and the parents didn’t speak English, so the supervisor, who was not bilingual, and I, were going to see this family together. She was going to be present because she knew what she was doing and I was brand new to the job... she was going to say ‘ask them this,’ and then I was going to talk with the family. And it was my first day of work... I had been there about a half hour when I found out that they were coming.

Although this participant had her supervisor providing basic guidance, without an interpreter or knowledge of Spanish, the supervisor possessed clearly limited ability to supervise the clinician. While use of interpreters in providing services was rarely discussed by participants, one participant recalled a post-doctoral supervisor employing an interpreter:

For a period of time after I was licensed but before I was on all these insurance panels during postdoc, my supervisor still had to sit in the room while I interviewed the patient so he set up this thing where I spoke Spanish with the patient during the interview, and the interpreter sat with my supervisor and interpreted for him what we were talking about.

Acknowledging her initial fear of an interpreter criticizing her linguistic abilities she observed:

That was really a great experience for me, because there were several different interpreters over a period of a few months, and they all said, ‘Wow, you know, you speak great Spanish.’ And to sit and have the interpreter listen to me and then interpret what I was saying for my supervisor, I felt like, you know, that was really the best sign I’ve had about my ability. You know, it gave me the most confidence.

The confidence building aspect of having another Spanish-speaking person in the room points to a key benefit of Spanish-speaking supervision that is lacking when simply receiving supervision from English-speaking supervisors.

Even in a Spanish-speaking clinic, supervisors may not speak fluent Spanish, as attested to by two participants. One participant working in an urban clinic dedicated to

working with Spanish-speaking clients noted “my supervisor did not speak Spanish [fluently]. She had rudimentary Spanish.” Another participant similarly noted:

When I worked at [another] clinic, I was being supervised but not by a Spanish-speaking person so I was doing that work kind of solo. It was a Spanish-speaking clinic, and there were lots of Spanish speakers there, so it was not like it wasn’t part of the dialogue, but my supervisor wasn’t [Spanish-speaking].

Trainees and clinicians working with English-speaking supervision and Spanish-speaking clients often navigate clinical situations with inadequate supervisory support. This occurs even when clinicians have been hired specifically to provide services in Spanish, including clinics that specialize in working with Spanish-speaking clients. Lacking support, clinicians with English-speaking supervisors struggle to provide culturally competent and linguistically accurate services and often experience concern regarding their cultural, linguistic, and clinical competence. When possible clinicians may turn to non-clinically trained individuals for feedback whether interpreters or Latina/o friends.

Experience receiving supervision from Spanish-speaking supervisors. On the other hand, those participants with the opportunity to receive supervision from a bilingual supervisor discussed a wide range of experiences. One participant observed that Spanish-speaking clinical services are “obviously not a huge focus” as one out of his twelve supervisors are Spanish-speaking. Whether intended or not, this communicates to clinicians that a focus on providing services to Spanish-speaking clients is not valued to the degree of services for English-speaking clients. Another participant noted a range of support in her experiences as a clinician in training:

In previous training sites where the expectation was I would see their Spanish-speaking population, there were some supervisors who spoke Spanish. I find that systems are not always set up, like sort of in an administrative way, or supervisory kind of way to support the clinicians or trainees who are coming in who can provide the services in Spanish.

Working with a Spanish-speaking supervisor increased participants' insight into their work with Spanish-speaking clients, providing them invaluable support to enhance the quality of their clinical services including linguistic abilities:

I had a supervisor who spoke Spanish and we did supervision in Spanish, or both [Spanish and English]. She was Puerto Rican, grew up in the United States, in New York, her parents spoke to her in Spanish, so she was bi-cultural and bilingual and she was a very good supervisor for me and we were able to talk about language, we were able to talk about the culture and I got a lot of support there in doing that work.

Another participant recalled:

I remember being able to talk about dreams that my patients had, in Spanish, and some of what that might mean culturally for her, or personally for her, I mean just to be able to do it [supervision] in Spanish means that I didn't have to add an extra layer of translation to what was going on. I think it's great that I had that opportunity.

Supervision in Spanish enables more direct discussion of clinically relevant material, whereas supervision with monolingual English-speaking supervisors requires that all information reported by a Spanish-speaking client must first be translated with varying levels of accuracy:

People would present their cases in either Spanish or English. And then we'd get feedback in Spanish or English. It was always completely bilingual that way. Working with more than one bilingual clinician provided one participant the opportunity to discuss clinical issues in a group setting. Even among those receiving Spanish-speaking supervision, supervision quality and quantity varied greatly. One participant experienced the full range of supervision from working solo to multiple bilingual supervisors:

It's been an amazing difference from having supervisors who speak Spanish to being the only one who speaks Spanish at a place and being given Spanish-speaking patients but not having a supervisor who speaks Spanish. Discussing her experience of having multiple supervisors who speak Spanish, this participant provides a clear example of the linguistic benefits of supervision in Spanish:

I've had Spanish-speaking assessment supervisors at internship. And that's been really helpful in learning the specific vocabulary of the assessments, learning, and practicing the assessments in Spanish. I am really picky about the language. I really think it's important for me to try to learn the technical terms and so that's been one goal for me this year, where they've given me four or five Spanish speaking supervisors, I do a lot of my supervision in Spanish....Then also trying to learn what are the clinical terms, because previously I had supervision in

Spanish and I learned a lot of clinical terms of childhood disorders, but I didn't have as broad of a clinical vocabulary, so that's something that I've been learning a lot more this year....

Spanish-speaking supervisors assist supervisees' self-reflection when working in Spanish. A couple participants noted that supervisors experienced working in Spanish often helped them to discern their own difficulties with language and their anxiety surrounding working in their second language from clinical issues that are arising between their client and them. One participant specifically described a situation discussing a Spanish-English bilingual client with a bilingual clinician:

I was talking to my supervisor, saying "I'm really surprised, I didn't think he was narcissistic, but I'm really feeling that there are these narcissistic qualities." Part of that was that it was almost as if he would forget that I spoke Spanish from one week to the other. He would be telling me something that was very culturally specific and then he would forget the word and he'd say it in Spanish, he'd be like, "my uncle has these plantations of ... [*caña* (sugar cane)] I don't know if you'd know what this is." And I'm like, "well tell me what it is" and he said this all in English of *caña* and I'm thinking, 'of course I know what *caña* is!' I'm like, "yeah I know what that is." I talked a lot with my supervisor about his reaction and my reaction to what he said and his forgetting or implying that I didn't know something. I was ashamed that I had that strong a reaction and my supervisor was much more tolerant and non-judgmental and said "I think this is the reaction that he provokes in a lot of people and that you may feel like it's being specific to your language skills because something you've been sensitive to is whether you speak

Spanish well enough, how are you speaking it, and how people are perceiving you, but I think it goes '*más allá*' (further) than that."

By providing bilingual culturally-aware supervision, one participant's supervisor enabled her to process her personal feelings regarding working in Spanish, improving her ability to effectively work with her Spanish-English bilingual client:

I have one supervisor who is really supportive and he is a native Spanish speaker. He has been the most willing to treat me as a bilingual person and not as an American learning Spanish. He immediately said, "your Spanish is really good, we're going to do this [supervision] all in Spanish." He's really helped me think more about the different aspects of myself that are coming out in the different languages and integrating those two and he told me that he felt shocked when he heard me speaking English, that that was like weird that he heard me speaking English. That's been the most positive experience of supervision where we've had a lot of focus on the language and where I felt very supported and felt really validated, like 'you're doing good work and you're able to do it in Spanish.' Before that, I think people had to take it for granted, because they weren't in the session with me.

The recognition that only a Spanish-speaking supervisor could provide validation of her linguistic and clinical work in Spanish is one that must not be overlooked. The opportunity to improve linguistically, clinically, and to grow as a professional and a person through supervision is one that ideally every Spanish-speaking clinician would be afforded.

Benefits of receiving supervision from non-Latina/o bilingual supervisor. While the above examples largely touch on benefits of supervision from Latina/o clinicians, there are significant benefits to be gained from supervision by a clinician with a similar cultural background to the supervisee. While the benefit of self-reflection and awareness when conducting clinical work is commonly accepted, it may be difficult for clinicians to do so if worried about their supervisor's own values:

I had one supervisor who was bilingual, who was also an American who'd lived abroad for a while. And we did our supervision in English, but we talked a lot about cultural factors and we also talked about language a lot, so that was really helpful. I think it was also helpful for me in developing an identity as like an American, a Gringa or an Anglo American, I like that term more, who speaks Spanish.

This participant valued supervisors who recognized and treated her “as a bilingual person and not as an American-learning-Spanish.” It is important to also express that having lived for significant time in Argentina, she experienced significant pleasure and benefit working with an Argentine neuropsychologist as well:

When I was doing a lot of assessments in Spanish, one of the neuropsychologists I worked with was Argentine and I basically just spent the whole time with him speaking Spanish and it was Argentine Spanish and for me it was like a relief to finally speak [Argentine Spanish]. It's like oh my God, I get to say ‘vos’ (2nd person pronoun in Argentine Spanish) and someone's going to understand me. He really helped me learn to do mostly brief assessments, but assessments in Spanish and also just clinical interviewing in Spanish, because I felt like I'd been doing a

lot of this like my best guess. And to finally get supervisors, previously I would ask people “¿Cómo está su estado de humor?” And he'd be like you know I would ask ‘estado de ánimo’ not ‘estado de humor,’ ‘estado de ánimo’ is a little better. Those subtleties, little tweaks have been really helpful.”

Recommendations regarding supervision. All participants emphasized the value of receiving supervision from culturally competent clinicians with experience working in Spanish including those with no such experience: “If you can manage to have a supervisor who’s supervising in Spanish, I really do think that that’s really a great advantage. and I do think it matters...”

Bilingual Latina/o clinicians framed as the ideal supervisor. Participants often framed the ideal supervisor for Spanish-speaking clients as a bilingual Latina/o clinician, with one participant specifying “bicultural, bilingual” suggesting that a supervisor who identifies with both American culture and a Latin American culture in addition to being fluent in Spanish and English, is the ideal supervisor:

I think it’s great if you can have somebody, who is Latina/o, training you and talking about the issues. If you’re working with Latina/o clients, I think it’s great if you can have a Latina/o supervisor who also speaks Spanish.

While the above participant referenced ethnic matching as a reason for Latina/o clinicians as supervisors, it is possible that for some participants, who knew few if any other bilingual non-Latina/o clinicians, the possibility of supervision by culturally competent non-Latina/o bilingual clinicians did not occur to them.

Based on participant feedback it appears that contrary to literature, an ideal training situation would provide clinicians with experiences receiving supervision from Spanish-English bilingual supervisors of both Latina/o and non-Latina/o background in order to more fully develop their understanding of both their patients and themselves. As noted by Falicov (2014) cultural competence requires not only outward awareness building through openness to other cultures and learning of other cultures but also directing focus inward, toward one's own cultural values, background, and biases. This suggests that for non-Latina/o clinicians, and Latina/o clinicians as well, a focus on identity development as a bilingual professional would be beneficial in improving training to work with Latina/o clients, especially those speak Spanish. Developing an inward focus will be valuable to improve work with all clients whose lives and values may not fit into the unspoken but very present cultural values, heritage, and assumptions of mental health in the US.

I would like to have somebody who had more experience than me, somebody who could critique my work, who could say this is what you're doing. I saw this session and I don't think you should say it this way. You know, someone who could help, who would tweak what I'm doing. Nobody has any idea what I do. You know, I'm in session and nobody's critiquing me I could just be making some mistakes that could really be easily corrected.... I would love to hear other people's perspectives because then I would learn from colleagues.

A participant who had never received supervision or training regarding working with Spanish-speaking Latina/o clients expressed desire for group supervision provided by both a Latina/o clinician and a non-Latina/o clinician:

You know I think if you ideally had yourself (referring to the PI) as somebody more experienced and a Latina/o who person who's experienced in a group of non Latina/o social workers and maybe some Latina/o social workers too or psychologists you know so you would learn to kind of help each other understand some of the cultural differences.

If you can manage to have a supervisor who's supervising in Spanish, I really do think that that's really a great advantage. and I do think it matters...I think it's great if you can have somebody, who is Latina/o, training you and talking about the issues. If you're working with Latina/o clients, I think it's great if you can have a Latina/o supervisor who also speaks Spanish.

Indeed, the topic of receiving supervision in Spanish was often suggested as a highly beneficial experience in supervision:

It would be very useful to have more direct supervision, possibly in Spanish. It would have been great to actually discuss the patients that I am treating in Spanish in Spanish. We discuss quite a lot of multicultural stuff, generally speaking, for APA, but I think something more specifically around how that translates to day to day practice with Spanish speakers would have been great.

Motivation by Spanish-speaking mentors. Four participants identified the support and encouragement of Spanish-speaking mentors as key in their decision to push forward with working in Spanish in the face of self-doubt. One clinician noted that when he was ready to give up on working in Spanish, his training director and mentor helped him persevere stating:

“This is something you can do and this is something you should do. And you have to start somewhere, and now is the time to start”. And the more feedback that I got like that from people who I felt not only had the clinical knowledge, but the linguistic and the cultural knowledge, the more I sort of just went for it.

Despite developments within the field including an increase in Spanish-speaking and Latina/o clinicians, relative to thirty years ago, current trainees still lack the supervision needed to learn to provide services to Spanish-speaking clients. Based on participants’ experience and recommendations, it is proposed that an ideal model of supervision would include supervision by bilingual clinicians from both Latin-American cultures, and non-Latina/o bilingual clinicians with experience conducting cross-cultural work with Spanish-speaking clients. This approach provides clinicians with the experience and understanding that to provide competent and effective clinical services one must reflect on their clients’ cultural values and viewpoints, as well as their own.

Clinician Experience Conducting Therapy in Spanish

Two thirds (8) of participants discussed their language of thinking while in sessions with Spanish-speaking clients. One third of participants (4) experience their cognitive processes in the language of communication, Spanish when communicating predominantly in Spanish, and English when communicating in English. One quarter (3) of participants noted that when engaging in mostly Spanish language work, they think in Spanish, but acknowledged that their language of thinking often fluctuates between English and Spanish depending on various factors. A single participant acknowledged thinking in English and translating her speech into Spanish when working in Spanish. This is important to note due to the added cognitive load this creates for a therapist,

leading to decreased ability to remain focused on clinically relevant information in session.

Experiencing anxiety working in Spanish. Nearly half of participants (5) experienced anxiety related to their Spanish ability at some stage of working with Spanish-speaking clients. It is important to note that this is an additional form of anxiety in addition to any concern clinicians typically have regarding their clinical abilities early in their career:

I don't really feel that now. The first, 6 months, I did have anxiety as I did the evaluations.

Another participant who identifies as fluent emphasized the distinct layers of providing therapy in Spanish:

Especially early on it was very anxiety-provoking because you know, my Spanish, I was pretty fluent and I'm still pretty fluent. I felt very comfortable understanding and speaking but [providing therapy] you're in a situation where you're doing a few things that you're very new at which is: one, being a therapist and that's anxiety provoking when you're very new at it and speaking Spanish in a different way. So it was speaking Spanish in a, in a therapeutic or clinical way. I had to access a different part of my brain and I hadn't really had a lot of experience talking to people in that way.

Not only is working in Spanish anxiety-provoking, similar to working in English, the task becomes more challenging when working with more than one client at a time:

I was very nervous when I first started doing groups in Spanish, even family, even couples. I think when there was more than one person in the room with me I just got very anxious and then I felt more and more comfortable doing it. Since I've come back from Ecuador I feel much more well grounded in terms of the cultural and contextual aspect, in addition to the linguistic aspect.

Anxiety impacted multiple participants' work, especially early in their Spanish language experience:

Early on, when I think the anxiety was probably my dominant emotion, I do think the therapy at that time was mostly supportive psychotherapy, so my ability to create an elegant interpretation was less necessary than my ability to be, to be a supportive, caring, listening presence. So in that sense, it was probably the best place for me to be anxious because whatever difficulty I was having processing my own emotions, not that that's not important, I think I was still able to do the primary functions of my work with those people and still express my caring through the anxiety that I had. I do think that my anxiety masked my ability to be particularly reflective especially during the early months of the externship.

For one participant, the possibility of not understanding clients' choice of words remains a constant a source of anxiety. Discussing her experience of not recognizing a client's choice of word she stated:

I have a panic attack. (laughs) Not really but my anxiety goes up pretty high. I have to really hyper-focus, you can't space at all so it's very tiring actually. When they [Spanish-speaking clients] are speaking very quickly or they have a strong accent, or dialect, I really don't really catch what they say but I get the gist. That

makes me more anxious, and then I just find like I need to kind of relax and I ask a few more questions to make sure that I understood correctly what they're saying.

While this participant describes a high level of anxiety, her awareness of it provides her the opportunity to manage it and channel it into an increased focus on attending to her speech.

Participants' anxiety often derived from self-imposed pressure, rather than from their clients' reactions. One participant discussed difficulty switching languages with bilingual clients and resulting internal pressure to improve:

I've found I'm more worried about it and aware of it than I think that they [clients] are or than they let on. I have found that I'm more frustrated with myself although I sort of project it on to them. I think that they would be frustrated, I think that they would be thinking 'Uch! Can't she get it together?' I'm more critical of myself and I think they're actually very patient with me and just so appreciative of even having the service.

This highlights the importance of this participant's ability to discern her anxiety and to distinguish her counter-transferential experience from her clients' opinions. Nonetheless, further exploration of the potential impact of clients' perceived appreciation would be beneficial.

Decreased anxiety regarding language. Growth in Spanish-speaking skills leads to a lessening of anxiety and an ability to be more present in session:

Over time I was doing Spanish-speaking work so much every single day that it wasn't something I thought about it, it was just what I was doing. I wasn't

thinking about my own Spanish, I wasn't thinking about if I was doing it right and then I think I was able to really be much more emotionally present with the person, and then it became much more like any other therapeutic interaction where I was over time more able to become aware of my own counter transference, the kinds of emotions that were coming up with a particular person, and it really was much less about the language 'because I was just so used to doing it.'

Addressing Spanish-speaking ability and fallibility. One third (4) of participants discussed that early in therapy with Spanish-speaking patients they explicitly discussed their Spanish-speaking ability. These statements often focused on the clinician's non-native Spanish speaking status and may also seek to anticipate and normalize that one or both parties may ask for clarification at points throughout discussion. The phrasing and the framing of this can vary greatly depending on the clinician. One participant chooses to directly address the fact that she is not Latina while recruiting the client in assisting her with her Spanish:

My first thing I say is that "I know I'm not Latina... but if you help me with my Spanish I'll help you with your English" ...and, you know, my Spanish is, I always say "my Spanish isn't perfect, but I understand everything, if I didn't I wouldn't be doing this job." So I try to make that clear from the get-go.

The manner in which this is done can be used as an example of potential pitfalls in addressing this issue. By placing a client in the position of a language teacher or coach, the clinician shifts the relationship away from focus on the client. Given the power difference in the relationship it is vital that clinicians examine the forced choices they

may pose to clients. The phrase “I’ll help you with your English,” connotes at least two assumptions on the part of a clinician. It assumes that a client wants to improve their English while in therapy, and it assumes that they would want to receive that assistance from their clinician. It appears that the participant above may project her own desire for assistance with language onto her clients. In the process of addressing issues of language, she stumbled into issues of setting an unintended tone for the therapeutic relationship by committing a microaggression toward her client. Another participant acknowledged that he makes qualifying statements regarding his Spanish, due in part to his concerns regarding his Spanish-speaking ability:

I’ll almost always preface the first few meetings with Spanish-speaking patients that I’m not completely fluent and there may be times when I need to ask what this word means. Or there may even be times where I feel like I need to pull the phone interpreter in. And then the feedback will often come at the end of the session, you know, “Why did you say that? You can actually speak it really well.”

Obviously, I’m a *gringo* and I can’t speak Spanish, perfectly. So, if there’s something that I’m messing up, please tell me.

;

And I did come up with that mantra to support myself in some way, but also to let them know that, you know, let's point out the obvious, here. My Spanish isn't perfect, so you're going to have to correct me sometimes. Or you may have to stop me, or I might have to stop you sometimes, or I may have to ask you sometimes. And that's okay. And if it's not okay, then we'll figure out a way to get around it.

This second example successfully focuses the discussion on the clinician's linguistic ability without making any assumptions or judgments regarding a client's English ability. On the other hand, it continues to place the burden of correcting their clinician's Spanish on the client. While some clients may be comfortable doing so, it is important they not be required to do so. The second participant briefly alludes to the possibility of this situation not being "okay" and later noted a willingness to involve an interpreter. While beneficial to discuss the situation and the alternatives, it is important for clinicians to recognize the lack of power clients, especially those with limited English proficiency, have when seeking mental health services. A forthright discussion of clients' opinions or experience of a clinician speaking Spanish is unlikely to take place due to this power differential and deference to medical professionals. Indeed, one participant noted belief that acknowledging difficulty with language may help ease the differential of power:

I am aware of hierarchies in general in therapy and I think that it puts people at ease because for whatever reason it kind of brings it down and I always say at the beginning, "you can probably tell that you know, I wasn't born in Santo Domingo

but you know, if there's anything that I say that you're not clear about please ask me to repeat it or I might ask you to say things another way from time to time."

Discussing one's ability to communicate in Spanish with clients is a complex task. For better and for worse, it is a step down from the pedestal which mental health professionals are often placed on by Latina/o clients. In doing so it is important that clinicians explore their reason for doing so and the language they use. If it is to manage their own anxiety, perhaps better to address the situations as they arise. If performed to communicate the norms of interactions desired, then perhaps a clearer discussion of therapeutic norms may be called for instead. Either approach requires that clinicians strike a delicate balance between honestly expressing the extent of their abilities while making certain that the clients' feelings and experience take priority over their own.

A third participant, with the highest level of education and length of residency in Spanish-speaking countries, more specifically framed possible communication difficulties as predominantly due to differences in dialect:

I went to school for a while in Chile and Argentina, so sometimes I may use words that you don't understand and you know you're from Mexico, you may sometimes use words that I don't understand, so let me know if you don't understand something I'm saying and I'll let you know as well.

This clinician explains, anticipates, and normalizes possible communication difficulties in a manner that addresses a solution, asking for clarification, without placing express responsibility on either person for the other's understanding, only their own. The statement also conveys an implicit confidence in her own ability to communicate with her clients.

Managing situations of linguistic difficulty. Participants reported a range of methods for managing linguistic difficulty in session summarized in Table 1 below.

Table 1

Methods of Resolving Communication Difficulties

Clinician's Action When Uncertain of Client Meaning			
Situation	Method of Resolution	Percentage Used	Participants
Clinician does not know a word client uses	Ask the client	100%	12
	Look up word in a dictionary	42% / 25% in session	5 (3/5 in session)
	Take no action	25%	3
Clinician uncertain of how to communicate a concept	Use a different word or phrase	83%	10
	Client offering assistance	33%	4
Client not understanding clinician	Circumlocution: using multiple words to express idea	42%	5

The most common, and crucial, response to clients using unfamiliar terms is to ask:

You need to have the foundation [of Spanish knowledge] but I think more than anything, you need to have the willingness to put yourself in an uncomfortable position. To be willing to say, I don't understand what that means. The first time I heard *guagua*, and I had no idea what *guagua* was, I asked. And I think asking and being open is important. Just having that foundation [of Spanish knowledge] and the ability to be uncomfortable for a little bit and open and willing to ask....it happens and you [the clinician] just intervene and say, 'I'm sorry, I don't understand. What does that word mean?'

Another clinician addressed the process of asking for clarification:

It happens and you [the clinician] just intervene and say, "I'm sorry, I don't understand. What does that word mean?" and then they'll go into, "it's like this." And *guagua* was a pretty funny. I couldn't figure out what *guagua* was. At first I thought it might have been like a dog. So, it just took a while to pick up. So, I just had to ask, "Wait, what is *guagua*?" There was a little bit of giggling, a little bit of laughing by the client who said, "It's the bus." "Oh, okay." So, again, that's sort of being able and being comfortable [enough] to confront possible things that you don't know.

Despite the popularity and simplicity of this approach as seen above (Table 1), a quarter of participants acknowledged not always asking for clarification:

I think there probably were times when that happened and I should have clarified, but, I didn't because I felt some like maybe shame or anxiety about not knowing, not having understood, so I think that is one area where the interference was present.

Client responses to clinician struggling with language. Most participants who had received assistance from clients believed that clients enjoy providing them with the help. This is an assumption that merits further exploration on the part of the clinicians.

Clinicians' response to clients not understanding clinician. Two thirds (8) of participants discussed various experiences of clients not recognizing words or phrases they have used. Nearly half of participants (5) noted that they will choose a different word once they recognize that a client does not understand a word. One quarter of participants (3) will ask a client if they think they have not understood a word, while one quarter (3) also noted that their clients will sometimes state that they do not understand. Two clinicians reported that they are able to discern from a client's facial expression whether or not they understand. One clinician noted that as she occasionally has difficulty with pronunciation of words, when a client does not understand she will write the word down which usually solves the confusion.

Difficulty due to ambiguity between dialects. Participants discussed a range of instances in which they were uncertain of a client's meaning due to use of terms from dialects they were unfamiliar with at the time:

The way you say “bus” in the Caribbean in Ecuador means “child, like small child” so if you say, “I’m going to take the bus,” in Ecuador it means ‘I’m going to try to have sex with the child.’

This anecdote refers to a complicated linguistic exchange for two reasons as the phrase the clinician is referencing ‘*Voy a coger la guagua.*’ contains two words with distinct meanings depending on region. As noted above, the sentence can mean ‘I’m going to take the bus’ or ‘I’m going to have sex with the child (more commonly ‘baby’).’ There are two words in this sentence, *coger* and *guagua*, that have distinct meanings depending on the regional dialect. In South America, *guagua* can mean baby, while in Puerto Rico, the Dominican Republic, and some other regions, *guagua* means bus. The second layer of complication in the example derives from the fact that the verb *coger* has distinct meanings depending on the country. In some countries such as the Dominican Republic, it means ‘to gather, collect, or take’, while in other countries including Mexico, Venezuela, and Argentina, it means ‘to have sex.’ The potential for confusion and misunderstanding as a result of such regional variations in dialect and meaning were reported by two-thirds of the participants (8) who experienced confusion or misunderstanding due to either themselves or clients using words that have specific meanings depending on the region of the speaker.

Participants discussed a range of vocabulary confusion from relatively innocuous vocabulary differences including types of shoes, (e.g., *zapatilla* vs. *tenis*) to more significant differences. One participant’s use of the word *coraje* (anger or valor) confused a colleague who interpreted *coraje* to mean anger, although the clinician intended the second meaning of ‘bravery.’

Another participant noted that words to describe types of housing can differ in their meaning from one country to another. One clinician noted being stumped by the implicit and explicit meanings of a Mexican term for a type of housing:

She was talking about her childhood and growing up in this rather wealthy family and then they lost their money and she's like “*y nos tuvimos que mudar a una comunidad*” (And we had to move to a community)” and I said “You had to go to a community ...so what? I'm not getting something here, because I don't understand what was so bad about that. And she said, “No, una ***comunidad*** [emphasis added by participant] ...” She explained that it's like a tenement house or a kind of compound in a poorer community. I talked to my supervisor who's a Spanish supervisor afterwards and we were talking about the class differences, and what the housing was like in Mexico. When I looked it [*comunidad*] up it was very particular to Mexico, that use of the word.”

Clinicians identifying specific dialects as difficult. Two clinicians who first learned Spanish in Spain noted difficulty understanding colloquialisms from others countries:

I think that I definitely had the biggest learning curve in terms of the Spanish language being different in like Puerto Rican and Dominican communities as opposed to in Spain, and also sort of it not, it not being academic Spanish.

Another clinician who lived in Spain reported causing her clients confusion at times because “colloquialisms from Seville are very different from the ones from Mexico and Puerto Rico and other countries.” While finding herself surprised by clients' confusion she acknowledged “there's no reason they should [know the words], there are

words in Spanish from Spain that aren't used in everyday language in other cultures.”

One participant who worked with mostly Dominican clients prior to traveling to Ecuador noted facing another learning curve when living abroad because “a lot of the words that were common in the Dominican communities are bad words in Ecuador.”

Another clinician admitted confusion due to different meanings in dialects noting “Everybody uses different words so I think I understand it but I don't because every country uses something different.”

Negative attitude toward dialects and colloquialisms. Some clinicians referred to whether or not words could be found in a dictionary as if measuring the words' value. It is important that clinicians develop greater awareness of tendency to describe colloquialisms they are unfamiliar with as “slang” or suggesting that because words are not found in a dictionary that they are “made up.” Indeed, this attitude may be echoed by native Spanish-speakers at times, although such sentiments hold no therapeutic benefit in a clinician's interactions with Spanish-speaking clients:

I didn't know what *mande* meant...so I'll say “*mande...que significa mende?* (*Mende*, what does *mande* mean?)”, I'll ask them to explain. Or I'll go down to the secretary who's Puerto Rican and I'll say “what word was that?” and she'll say “Oh, we made that up.” That's good, it's a made up word... Like *guagua*....do you know what *guagua* is? In Puerto Rico....*guagua*....it's an *autobus*, it's a *guagua*... I remember when I lived in New York, they would say “I'm going to go catch the *guagua*”, like the ‘*guagua*’? And I'd be looking in my dictionary where the heck is *guagua*? And I would find out...so now that's my joke with the like the Puerto Ricans because I'll say “just like you use *guagua*,

where's that in my book?" You know, just the way we use colloquialisms, that it's like don't make any sense...right?

While not explicitly negative, a participant referred to Dominican clients as using "more slang." When using words such as "slang," it is important that clinicians examine their underlying meaning. While slang is another word for colloquialisms, which exist in all dialects of Spanish, and all languages, it often comes weighted with a negative connotation.

Relying on leniency due to being "American." One clinician noted that while she is not aware of specific instances of either her client or her using a word with a dual meaning, she noted that she feels she can "get away" with using a word with possibly different meaning as her clients "know I'm American... so they kind of get that I didn't mean it that way." While seemingly aware of the need to choose her words carefully, this participant's reliance on clients disregarding her mistakes due to being an "American," suggests a surprising level of comfort relying on this form of privilege and a possible downside to being viewed as a non-native speaker.

Linguistic difficulty complicating clinical tasks. Doubts regarding competence in Spanish may increase at times when working with unfamiliar dialects. One clinician noted that while she had experience with dialects of Spanish spoken in Mexico and Spain, her first experience working in a predominantly Dominican setting was difficult:

I hadn't encountered that kind of Spanish where the words were very different and you know they often will cut off the end of the word, so I had to figure out what they were trying to say... that was confusing because I didn't totally understand what they were saying then add another layer which is I was working

with psychotic patients. So now you're talking about figuring out what my own issues with the language and then trying to suss out "is this a person who's thought disordered? ... Are they talking about delusional material? I have to figure out, what their thought process is, in their own language which has an accent and a dialect that I'm not totally familiar with.

Decreased effectiveness when working in Spanish. Others reported experiencing less effectiveness when working in Spanish. For some this surfaced in the form of decreased fluidity describing clinical concepts. Others reported having difficulty identifying clinically-relevant information such as that a person had attended session under the influence of alcohol or that a person had an intellectual disability. While the clinician who had seen people under the influence of alcohol did not recognize it in the initial session ascribing difficulty to client accent, she noted a difference the next session and realized "oh they were a little wasted that session."

Other participants' decreased fluidity in Spanish has left them lacking the words to express their thoughts:

I've definitely been at a loss for words, where I didn't know how to say it. So, I've worked around it or worked with the patient on finding the words, which I think goes back to the "how smoothly are my sessions running?" in that we had to stop in the moment of process to figure out what I wanted to say, which isn't great. And it is what it is.

Clinicians noted that clients may offer them a word they are having trouble remembering. One participant noted early on in her experience of working in Spanish, clients "would offer a verb, they would know a verb I was looking for and they would say

it, or, that polite way of correcting a verb form, which is just sort of, involuntary, automatic in language.” Another clinician noted that they would acknowledge their difficulty finding the right words saying “‘*gracias por su paciencia, no soy hablante nativo de español, y se me olvidó la palabra.*’ {Thank you for your patience, I am not a native speaker of Spanish and I forgot the word.} So, people are always very accommodating and very kind and I just own up to it.” Beyond simply acknowledging their difficulty finding words participants noted that they will sometimes ask their clients for help when trying to find words “sometimes I ask, or if I kind of explain what I’m trying to get at then they’ll say the word...” One participant noted that asking or receiving help with vocabulary from clients can be a complicated balancing act stating “I try not to make them feel like they’re teaching a Spanish lesson.”

Yet another clinician noted that when struggling to find words he chooses to “not bother...or I will get to it later.” This decision to “not bother” suggests that there may be many times when a clinician’s level of Spanish fluency may subtly diminish the quality of services that their Spanish-speaking clients receive. It is not possible out of context to determine if this made a significant difference, but the attitude that one may delay, or simply not say, an idea due to difficulty communicating suggests that clinicians and trainees may be placed in situations for which they do not possess appropriate levels of fluency.

While many participants suggested a loss for words may negatively impact provision of services, two participants suggested it has no impact, and may even be seen in a positive light:

I don't ever have a problem getting my message across. It might just take a little more time, or a little more clarification.

Another participant reflected that finding herself at a loss for words reduced the amount she talked as she often opted instead to remain silent or ask a question, and noted "in the end I'm not sure it matters so much if I said the thing that I felt I needed to say in a given moment."

Clinician difficulties understanding spoken Spanish. A number of participants noted difficulty understanding Spanish-speaking clients. Five participants attributed their difficulty to their clients' characteristics. The characteristics noted ranged from clients' use of colloquialisms, to clients speaking a dialect unfamiliar to clinician, speaking rapidly, clients' level of education, and clients having physical speech impediments such as missing teeth.

One participant noted difficulties may be caused by multiple factors at times, "if they're speaking very quickly or they have a strong accent or ...a strong dialect...I don't really catch what they say but I get the gist.... and that makes me more anxious. Then I just find I need to relax andyou know.... I ask a few more questions to make sure, particularly in an assessment, to make sure that I understood correctly what they're saying..." One participant recalled difficulty understanding a client who spoke a dialect with significant indigenous influences, noting "even the Spanish interpreter, a native Spanish speaker, couldn't pick up what the guy was saying." Other clinicians discussed difficulty understanding clients for a variety of reasons, some highly specific such as missing teeth, low educational level, use of colloquialisms, while others reported difficulty understanding clients who "have strong accents" or whose speech is "dialecty

or slangy.”

Difficulty understanding due to unfamiliar dialect. While some participants conveyed a sentiment that the difficulty lay with how their clients spoke Spanish, other participants explicitly acknowledged that their specific experience with certain dialects contributes to difficulties. Three quarters of participants (9) reported that they faced difficulties when working with clients who spoke a dialect other than the dialect with which they are most familiar.

One participant noted “most of my work has been with people from Mexico and Central America...it’s just easier to understand them and I think that sometimes I have trouble with people who are like from the Dominican Republic, I think they’re speaking in more like slang, there’s a little bit of a different accent.” While most participants suggested that they could overcome or work around any difficulties understanding clients, this same participant acknowledged that difficulty understanding a client’s dialect may require her to refer a patient out noting “I haven’t worked with any people who are from Puerto Rico or the Dominican Republic...so I may have to eventually refer that person to someone else if I’m not understanding them.”

Clinician characteristics impact understanding. During the interview, participants noted various language-related factors on the clinician side of the equation that impact provision of services in Spanish. A number of participants reported experiencing significant anxiety early in their experience of working in Spanish. These participants noted that their anxiety was often related to dual factors of their ability to speak Spanish and their ability to conduct therapy in Spanish. This anxiety was noted to

impair their effectiveness early on in their experience providing therapy to Spanish-speaking clients.

While providing services to Spanish-speaking clients, clinicians report a range of factors that negatively impact their understanding of clients, including, but not limited to their own anxiety, dialect, use of colloquialisms, different levels of education, and speech impediments. Given the variety of dialects spoken in the US, it is important that clinicians make efforts to familiarize themselves with those dialects of Spanish spoken by Spanish-speakers in their surroundings. Furthermore, clinicians possess their own positively and negatively biased views of Spanish dialects. Whether these views are based in personal biases developed from Spanish teachers, travel to foreign countries, other Spanish-speakers, clinicians, or other sociopolitical forces, it is important that clinicians become aware of their biases and seek to reduce them. Without this awareness, clinicians may be at risk of insulting and offending not only their Spanish-speaking clients but also colleagues, and friends, when they reveal their biased attitudes toward regional forms of Spanish.

Issues of Identity Impacting Service Provision

Throughout the interview issues of identity, for both clinician and clients, arose in discussing work with Spanish-speaking clients. When asked directly participants discussed their impressions of the degree to which their own identities did and did not impact their work with Spanish-speaking clients.

Religion and spirituality. All twelve participants discussed religion and spirituality in various ways. According to nearly half of participants (5) issues of religion or spirituality rarely arose in conversation. One quarter of participants (3) felt that religious beliefs and spirituality arose more often than not when working with Spanish-speaking clients, in a variety of forms. While shared Christian faith was noted by two participants as helpful with rapport building, two participants noted religious and spiritual beliefs related to *espiritismo* and *Santería* as obstacles to treatment.

One clinician discussed working to help a religious client with an external locus of control develop a more active coping approach whereas her religious beliefs tended to contribute to a more passive method of coping with difficulties in her life. Another clinician discussed a young man from a religious family who experienced an early psychotic break but did not remain in treatment as his parents understood his psychotic break to be a sign of a calling or a message from a deity, as opposed to a psychiatric illness to be treated. This clinician noted offering the family to invite a member of their faith community into the treatment process but that the family was not interested in continuing within the psychiatric model of care.

Spiritual beliefs outside of mainstream religion and psychiatric beliefs. Three clinicians discussed patients discussing religious concepts that do not always fit within the psychiatric framework. Two participants noted clients with significant involvement in Santería, one of whom reported out of body experiences as a child. The third participant noted working with a number of patients who had seen the spirits of deceased relatives, a culturally normative experience which does not fit within the European American

concept of typical experiences of people without mental illness (Guarnaccia and Rodriguez, 1996).

Clinician awareness of race. Ten participants acknowledged that race influenced their work with Spanish-speaking clients in one way or another. Importantly, two participants appeared to discount the relevance of their race on clinical work noting that clients are "used to" health providers being White. While the predominance of White professionals has been well-documented, this does not support invalidating clients' experience by regarding race as irrelevant to their clients' life experience.

Varied awareness of impact of race on session. While one participant reported increased comfort acknowledging her White identity in session, another participant appeared less willing to take a critical stance. She expressed a belief that working with White clinicians "helped break down cultural barriers that they [clients] have going out into the world in the United States, you know, recognizing that there are Caucasians that are open-minded." While this seems possible, it would require a culturally competent provider which cannot be assumed.

Clients' colorist beliefs. One third of participants identified clients holding beliefs founded in colorism, a belief that the lighter a person's skin is, the smarter, better, more good-looking they are. One participant observed that "clients often hold culturally-based beliefs that people who are lighter-skinned and White are more knowledgeable, and smarter over all." Another participant noted "I think in a lot of different cultures but very much in Dominican culture it's the lighter your skin is the better it is, the better you are." While this was noted by clinicians, no one addressed the broader consequence of such beliefs on clients' life experience within and without the therapeutic relationship.

Race as an obstacle to working with Spanish-speaking clients. While two participants framed discussion of racial differences within the therapeutic relationship as a useful transition topic to discussing issues of trust, close to half of participants (5) discussed being White as an obstacle to their therapeutic work with Spanish-speaking clients. Obstacles included clinician skin color and race leading to assumptions of an inability to understand their clients and their experience, with a couple participants having clients assume they speak English only. One participant observed “the most striking thing about my experience is that the client will come in and take a look at me and think to themselves, ‘Oh, no. He doesn’t speak Spanish.’”

Fear of disclosing immigration status to White clinician. Two participants noted belief that their race contributes to undocumented clients experiencing concern and mistrust regarding disclosure of undocumented immigration status. One participant reported attempting to set clients at ease by repeatedly emphasizing the confidentiality of the therapeutic relationship. It should be noted that she did not discuss how she determined which clients are undocumented nor discuss having straightforward discussions of legal status and confidentiality with clients.

Discomfort facing stereotypes of race and socioeconomic status. Two participants shared experiences of patients expressing what they perceived as race-based assumptions, notably both stereotypes that served to distinguish and distance the clinician from the client. A participant working in Manhattan noted clients often assumed she resides in New Jersey in a house with a white picket fence, or Brooklyn, both which she noted were “not at all accurate.” Another clinician told by a client, “White people work all the time, there’s no family life” worked to counter this belief, labeling it a stereotype,

noting “there’s a lot of people who work really hard and, you know, White and Hispanic and Black and Asian. But, you know, we do our best to spend time together as a family.” Notably in both cases, facing stereotypes appeared to generate defensiveness on the part of the clinicians, leading to attempts to counter the stereotype, rather than exploring the implications of the beliefs within the therapeutic relationship.

Another participant discussed discomfort when a client expressed appreciation for being seen by a Latina nurse. The participant noted being initially concerned that the client was suggesting that if the clinician were from her own culture she would be more comfortable, the clinician then noted recognizing the truth of this without feeling defensive.

Acknowledging clinician’s economic privilege. While four participants noted that most of their Spanish-speaking clients are of low socioeconomic status, only two participants noted their economically privileged status and their clients’ lack of privilege in session with clients. Two clinicians who noted their economic privilege made no mention of addressing this explicitly with clients in sessions. Two participants with a limited number of Spanish-speaking clients in private practice noted differences between their private practice clients and their lower socioeconomic status clients often seen in community mental health clinics.

Navigating Boundaries

Most participants expressed awareness of navigating different expectations and experiences of appropriate boundaries, physical emotional and therapeutic, while working with Spanish-speaking clients:

My training would say you know the boundaries are these four walls, we talk about feelings, we don't act on them, ...you know I'm not going give you a hug but we can talk about your desire to give me a hug...(laughs)...right? And in the Latina/o community, I'm less likely to keep that strict of a boundary...it was more likely that a hug would happen.

More casual and open with Spanish-speaking clients.

In general, there's just a level of maybe being more casual, being more familial, being more open about yourself, about your family, about who you are, how I learned Spanish, where I lived when I learned Spanish.

One quarter of participants (3) discussed experiences of being asked directly "Why do you speak Spanish?" and one third of participants (4) discussed having been asked, "Where are you from?" Both these questions were experienced as expressing curiosity and at times confusion regarding the clinician's ability to speak Spanish. Participants noted that they typically explain how and why they learned Spanish. One participant noted "I get a lot of that question of why do you speak Spanish, or where did you learn Spanish, or why are you working with Spanish-speaking population. And that's something that I'm very open about and I'll talk about. And I think that gives them a little bit more insight." Another participant reported having "a pat story...I went to school for a while in Chile and Argentina.... And with that most people are like, oh okay."

Greater use of clinician's self. Nearly half (five) of the participants mentioned more frequent use of self when working with Spanish-speaking clients. While one person framed it as a conscious decision of "being willing to share a little bit of who I am as a person," others described it as a natural, inevitable occurrence when working with

Spanish-speaking clients: “there’s an extent to which I am kind of inevitably using my kind of, myself and my general experience as kind of a therapeutic tool.”

Less formal boundaries. Two participants who had received invitations to social events from Spanish-speaking clients interpreted the underlying meaning of the invitations quite differently. One clinician perceived it as a sign of clients’ ignorance of the therapeutic process:

They don’t always understand how this all works.... it’s very flattering. I explain to them that I can’t. That while I enjoy knowing them and working with them I’m not able to socialize with them.

Another clinician contradicted this view, crediting clients with understanding therapeutic norms but hoping to communicate an underlying message of caring and interest:

There’s awareness that I wasn’t necessarily going to come visit them at their house, but there’d be a sense of like ‘you know, you can come over for dinner if you want’ or like, sort of like, an expression of ‘I want to include you in my personal life’ in a way that just wouldn’t get said by other folks.

The more personal connection and boundaries often displayed by participants was illustrated in mentions of clients being “more likely to pull out pictures and show me pictures of their family...including me and inviting me into their personal life in a behavioral way rather than like a verbal way...or bring me baked goods.” One third of participants had received small gifts from clients and expressed greater openness to accepting gifts from clients, while processing the exchange, with one clinician noting “so much more likely to bring me a gift from their visit home, or to bring me a Christmas

gift, or to give me a Christmas card.” Indeed, regarding the increased likelihood of this, one participants’ supervisor offered advice regarding such interactions:

You want to occasionally accept if they’ve baked for you and if they, you know, want to give you something, as long as it’s small and reasonable. That the traditional view of these very firm boundaries have to be softened a little bit.

A quarter of participants (3) received physical demonstrations of affection from Spanish-speaking clients, and at times reciprocated the gestures. “They might reach out and pat my shoulder. They might give me a hug. They might kiss my cheek at the end of a session.” Interestingly, a participant posited a relationship between a patient’s age and affection noting that working with Spanish-speaking mothers 50 years of age and older, there is more physical contact between him and his patients which he accepts as culturally normative: “Walking down the hall, a hand on my back, sometimes there will also be kissing on the cheek, something that I do not do with any of my English-speaking patients for whatever reason.” Forethought and reflection on how to navigate such moments are clearly important when working with Spanish-speaking clients.

Overall, working with Spanish-speaking clients requires non-Latina/o clinicians to do far more than speak Spanish. Managing and reflecting on clinician and client values, expectations, and experience, are vital to competent service provision. Both linguistic and clinical skill development require clinicians remain open to continued learning throughout their work in Spanish.

Chapter V: Conflict with North American Views of Mental Health

Most participants (10) experienced conflicts with North American conceptualizations of mental health in their work with Spanish-speaking patients.

Interrelationship of Mental Health and Supernatural Causes

One third (4) of participants worked with patients who believe in the supernatural, and viewed their mental illness as partly due to supernatural causes. Participants discussed various methods of managing their clients' discussion of supernatural or paranormal experiences.

Assess for cultural normativity and distress. Further, one third of participants emphasized exploring with clients the extent to they are distressed by their experiences. Choosing to validate a patient's beliefs regarding being cursed, allowed one participant to more closely explore the client's method of resolving the curse. Normalizing and validating the client's experience, the participant stated "thank you for telling me about this and you know I might not 100% share your belief systems but that doesn't mean I don't believe you or that I don't think this is real for you." Upon learning that the client hoped to employ a folk healer to lift the curse, the clinician explored the idea with the patient in a non-judgmental fashion. Upon learning more about the patient's plan, and her family's opinions, the participant discerned the chosen healer was not trustworthy noting "I know you want to make this work and I know you want to get rid of this curse, and I get that, who would not want to do that? But, we need to think about this reasonably. You have a limited amount of money...you've been told this person's a scam artist. "By engaging in normalization, validation, and engaging with the client's beliefs respectfully, this clinician was able to identify the possible negative impact which would have been

being taken advantage of financially, while further building rapport with the client. In similar cases, a clinician may send an even stronger message of support and understanding of a client's beliefs by exploring with a client with the possibility of locating a more trusted folk healer.

Another participant noted, "A fair number of my clients will report visual hallucinations of a deceased love one, and I've read lots and lots of reports saying how psychotic they are to report that, when it's just normative." One quarter of participants' noted that clients had shared beliefs characterized as pathological by the mental health establishment including out of body experiences, being cursed, and auditory and visual perceptual experiences, specifically seeing spirits and hearing one's name called. Participants noted seeing the spirit of deceased loved ones, and hearing one's name called are culturally normative in many Latin American cultures.

Participants expressed dismay and frustration that these experiences were pathologized by other clinicians in clinical reports. The cultural normativity of these experiences has been confirmed by various studies which have demonstrated that psychosis-like symptoms occur at a higher rate in Latina/os than among other racial and ethnic groups (Cassano, Fava, & Mischoulon, 2012; Guarnaccia, Guevara-Ramos, Gonzales, Canino & Bird, 1992; Lewis-Fernández, Gorritz, Raggio, Peláez, Chen, & Guarnaccia, 2010). At the same time, it is important that such experiences not be disregarded in the name of "cultural competency." While psychosis-like symptoms have been found to not predict psychosis, it is important to recognize that they are predictive of greater vulnerability to psychiatric difficulties (Lewis-Fernández, Horvitz-Lennon, Blanco, Guarnaccia, Cao, and Alegría, 2009).

Psychoeducation can be stigmatizing. It is important that clinicians recognize that by providing psychoeducation regarding clients' experience from a North American perspective, they may inadvertently stigmatize experiences and thereby cause more distress than they resolve.

There are times I think where North American clinics are trying to provide psychoeducation to clients about psychiatric disorders and I think there's times when that is very useful and there are times when probably we need to just leave our labels aside and just help the person talk about what the experience is...

One participant recalled working with a patient with a trauma history who had out-of-body experiences as well as a family practice in Santería. The clinician explained that out-of-body experiences are culturally normative in Santería, and did not label them as pathological experiences as past providers had, instead responding "let's talk about what it meant to you...this isn't necessarily a psychotic experience."

Expressing respect for patients' religious and spiritual beliefs. A participant working with a Central American young man hospitalized after a first-break psychotic episode discussed navigating the family's beliefs and resistance to mental health treatment:

The family, the parents, really felt like that this was more of a message from a religious leader, or from their god, than anything else, and that this could really be treated and solved by going to church. And they felt like their pastor could offer the enough support.

While viewing the family's views as an obstacle to proper treatment, the clinician took a conciliatory approach, seeking to involve the family and their religious leader, in discussing possible treatment options:

I spoke with the parents and said, you know, "Do you know of a *curandero* that we can have come in? Can we bring in your-, " I said "pastor," but it may be priest. "Can we bring your religious leader in? Can we all sit down so we can talk about what we can offer here...What the research says about this and also what they feel comfortable? And then, finally, you guys make the final decision on what you think."

Notably, the clinician did not simply assume that including the religious leader would resolve the resistance, assuming they would agree, but recognized that ultimately, the decision lay in the hands of the young man's family and focused on building rapport with the family noting:

I spoke some Spanish with them and a relationship was built to the point where the dad was like, "You should visit this island off of my country. It's beautiful. If you speak Spanish, you'll love to go there." But when it came down to it, they said "we don't want to go for treatment and we just want to go to our church and be followed there."

The end result on a concrete level was that the young man did not receive the advised mental health treatment. Yet it is vital to recognize that in many ways, this approach may have increased the long-term likelihood that his family will re-engage in the mental health system by conveying respect, support, and informing the family, while building rapport with them.

Advocating on behalf of clients' beliefs.

It was probably one of the more difficult and sad cases where I've seen culture, or really maybe just more religion, I think really negatively affect the family's ability to receive appropriate treatment. Again, something that I appreciate and never take for granted is my training in the Latina/o Mental Health Program [at MSPP]. And in many ways, I understand where they're coming from. This is a major mental illness, and unfortunately going to change this child's life in a negative way. Now, he may never have another break, I don't know. But this was a really unfortunate situation and very sad and just having to step back and accept it.

While interaction with the family could have ended at that point, or possibly reported to protective services, the participant did not end his work on behalf of the child and the family at that point. Instead he continued to advocate on behalf of the family and their beliefs while engaging with other clinicians:

It came up in the clinic, do we call the Administration for Children's Services? Is this medical neglect? And I really pushed not to, so I got consent to speak with the school. I got consent to speak with the pastor. I told the parents what I knew as far as what we know from our medical perspective. I said "It's limited but we have some data and I want to express it to the teachers and I want to express it to the pastor so people are aware so they know what to do and you guys have a plan in case he presents like this, again." And we put the plan into place and my guess is he'll have another break and hopefully enough of a relationship was built that they'll come back in, we'll see.

While the family may not have been completely aware of the discussions occurring behind the scenes, this interaction of providing information to other supports within the family's community, and informing the pastor, and the teachers, illustrates the value of a multi-systemic approach, as well as how to balance the needs of clients, respect for beliefs, and ensuring that needed treatment is received. This example serves as a model for best practices in engaging with and respecting clients' beliefs that conflict with the North American approach to mental health care.

When asked his thoughts on whether or not to call ACS with Spanish-speaking clients and families, he addressed the broader context within which clients develop their views of child protective services as well as his own views of involving protective services:

Spanish-speaking patients generally have a limited understanding of the system and how it works because the system is in English and because of horror stories that are told to them. Some that are true and some that are probably not. So I, as a Spanish-speaking therapist who works with Spanish-speaking patients, need to be very, very careful in walking that line and making it very clear to them what it means and what will happen and what are the consequences, both negative and positive. And when it comes down to it, it's about the safety of the child. So, if I feel, and I've consulted and we feel like the child is at risk, or any imminent risk or anybody is at any imminent risk, then I throw culture and language out of the loop. But when it's not as clear-cut, you need to be very clear and explain all the different things. Because I think there is an underlying mistrust of the system and there should be. There should be.

Further explaining his support for mistrust of ‘the system,’ this participant identified a critical milestone in his awareness of injustice faced by undocumented people in the United States:

When we were in graduate school, at New Bedford, they detained 40 different people and kids were split up from their parents. This was at a facility where the workers made backpacks for the government. So, they were employing undocumented persons and then they detained all these people. And there’s an underlying mistrust, yeah. I wouldn’t, If I was in that position, I wouldn’t trust anybody, either. So it’s a fine line that you need to walk.

Determination of when to contact child protective services. The above illustrated approach, of focusing on the rapport and education of a family rather than contacting child protective services immediately, was also echoed by two other participants. Those participants emphasized a belief that if they have not directly observed marks on a child that more is gained by maintaining rapport with a family already receiving services than by involving child protective services.

Balancing client’s values with client’s wellbeing. One participant specifically noted that they have felt conflicted when discussing a client experiencing financial stress due to remittances home. The participant noted that training emphasizes the client as an individual above all else. This clinician observed that she felt concerned about the impact of the stress caused by the client sending money home, but recognized the importance to the client of financially supporting other family members. While believing that sending money was causing an undue burden on the client, the participant made an effort “to work with the person to find you know a balance that felt okay to them, while respecting

their beliefs and what they felt was right.” This action of supporting the client to determine the level of remittance home that enabled them to meet their obligation to their family, while reducing the stress on them is a prime example of a clinician balancing respect for client’s beliefs while helping them to self-care.

Stigma and black and white views of mental illness.

I had one client who was very upset that her mother had died and she went to go dig up the bones of her mother...and [her family] said “she’s crazy, *está loca*.” and I said, ‘well, I think it’s trauma’ and we talked about it, and I explained more what she’s been going through.

As seen above, at times, participants confronted the stigmatizing reactions of patients’ family members. One clinician noted that one patient experiencing distress after the loss of her mother went to dig up her mother’s bones leading family members to label her as “*loca*.” The clinician discussed providing psychoeducation to her family regarding responses to traumatic loss.

Another clinician worked with a family who struggled to accept their daughter’s diagnosis of bipolar disorder:

I have one client who’s a very sick little girl...who has migraine headaches. And she’s bipolar and they [her parents] spoke to a cousin and the cousin said, “oh no, I think the symptoms are really just of a migraine headache...” So, I responded “Do you remember that she jumped out of the window?” but it was very hard to accept, that their daughter has bipolar disorder...and they really didn’t understand bipolar disorder. That’s actually why I am trying to connect more of my clients with NAMI and Spanish-speaking parents [De Familia A Familia De NAMI

(NAMI Family-to-Family)], I think is essential. I think that's going to be key because they need to speak to other people who understand family members don't understand what it's like to have a child who has a serious mental illness.

Another clinician described one experience of a client expressing their black and white view of mental illness:

In general, my Spanish-speaking clients have a black and white view of mental health/mental illness. Basically they think everyone they know and everyone in their family is mentally healthy and then there are some strange people out there who are mentally ill. Even the authorization [for treatment form] says something in Spanish about "this evaluation will be looking at your mental health." So I had one client who argued with me, saying "*No estoy loca* (I'm not crazy)," and I had to explain, "*Cada persona tiene un nivel de salud mental* (Each person has a level of mental health)."

While a basic explanation, this response focuses on the universal nature of mental health, rather than restrict it to the stigmatized concept of mental illness. At the same time, it emphasizes the importance of clinicians exploring forms with clients as they may interpret clinically neutral language in a negative manner based on their own views of mental health.

These anecdotes and past research on treatment barriers for Spanish-speaking clients (Echeverry, 1997; Rastogi, Massey-Hastings, and Wieling, E., 2012) demonstrate the importance of seeking ways to reduce stigma as a barrier to seeking help.

Difficulty understanding medical model of mental illness. Three participants reported that their Spanish-speaking clients often disagree with the medical model of

mental illness as a discrete entity. One clinician noted clients' disagreeing with their perception of North American approach to mental illness as "I have this biologically-based thing that I was born with, I need to take medication, and it doesn't have to do with anything else going on in my life."

Another participant noted that discussing depression as a diagnosis with a treatment and medication falls flat when she speaks to Spanish-speaking clients. She noted a depressed Latina client once observed "my kids left the house to go to college far away, and I'm really upset, I'm very sad...what are you talking about...a depression? I need medication? I need my kids to come back! I don't need medication." Similarly, the same participant worked with another client who explained, "I came to this country and my family's back in Ecuador... of course I'm depressed..." This view of mental health as predominantly in relation to other people in one's life, and to the broader social context is common in individuals from Latin American cultures (Falicov, 2014).

"Ataques de nervios." Four participants reported clients discussing "nerves," "*nervios*," or "*ataques de nervios*," Two participants discussed *nervios* or "*ataques de nervios*" as a vague descriptor often synonymous with stress and anxiety and including similar symptoms. Two other participants discussed "*ataques de nervios*" as a distinct entity although each described it in a different manner. One clinician identified "*ataques de nervios*" working with:

A woman who recently had two periods of short memory loss, both of them occurring after a funeral in the context of a lot of significant emotional distress. She had complete amnesia. She had amnesia for four hours the first one, and amnesia for about a period of a half an hour the second time. So North America

calls that ‘transient global amnesia’, but I think that she’s experiencing ‘ataques de nervios.’ So, you know, and she described the, the time she woke up from the first episode. She saw the saint from her small town in Mexico appear to her. The other clinician emphasized it as a reaction to anger or overwhelming emotional distress. Referencing unnamed research studies, he noted two subtypes of “ataques de nervios” AKA “Puerto Rico Syndrome” (Fernández-Marina, 1953; Salmán et al, 1998). He identified one subtype as “a specialized reaction of anxiety when somebody is feeling anger.... primarily with women. They’ll tell me about some situation that would normally make somebody very angry, and they say, “I get so nervous.” He then reported “there’s another variant of Puerto Rican syndrome that almost looks like an epileptic seizure... where they’re overwhelmed by some emotion.” The participant shared an anecdote of this second subtype of Puerto Rican syndrome:

In the case of a woman from – I think she was Dominican, and some of their associates in the Dominican Republic talked her into being a drug mule. So she flew into either La Guardia or Kennedy airport with a lot of drugs hidden on her body. She got busted, and she ‘fell apart.’ And the psychiatrist who examined her found she was shaking and all kinds of stuff. The psychiatrist who examined her thought she was faking an epileptic seizure. In my report to the attorney, I wrote, “This is Puerto Rican syndrome.” She’s Dominican, but it’s the same thing; that this is a characteristic reaction to being overwhelmed emotionally: having all this physiological stuff going on.

As seen above, this participant reported assessing Puerto Rican Syndrome, also known as ‘ataques de nervios’ when assessing a woman who had what had been labeled by a psychiatrist as a pseudo seizure.

Overall clinicians’ awareness and understanding of *ataques de nervios* and the meaning of them to their clients varied widely. While some clinicians appeared aware and up to date on the research, some clinicians simply imposed North American views.

Chapter VI: Clinician's Experience of Therapy

English-Speaking vs. Spanish-Speaking Clients

Asked to contrast their experience working in Spanish and English, participants discussed a number of ways that their experience of therapy differs whether working with English-speaking clients or Spanish-speaking clients.

Differences in stance. Almost half of participants (5) observed differences in their therapeutic stance when working with Spanish-speaking clients.

Less authoritative. Four participants discussed taking a less authoritative and/or direct approach when working in Spanish. A range of reasons were offered as reasons for taking a less direct and more collaborative approach with Spanish-speaking clients. Some participants attributed this more collaborative stance to working in Spanish and acknowledging their fallibility. One clinician noted that when working in Spanish he invites clients to correct him if he makes a mistake, noting that he does not invite corrections when working in English. He observed, “in English I’m an expert...I’ve never really thought about that before.” Three participants noted being less direct in their discussions with Spanish-speaking patients, being “softer” and “gentler” in how they phrased interventions when discussing possible solutions to problems. This is worth further exploration as the clinicians appeared unclear on their reasoning for doing so.

More sensitive to family's experience. This participant also noted that when working with Spanish-speaking children he is “quite sensitive to the family’s experience of things, tensions between generations around kind of acculturation and that kind of thing” and “more understanding of a disciplinarian parent or a parent with relatively conservative views vis-à-vis sexual orientation.” This clinician noted that working with

Spanish-speaking clients he tends to communicate “yes there are all these specifics and technical bits, but at the end of the day...” and I will try and loop it back much more to kind of “your relationship to your daughter” or “the family” or all of those sorts of things. So I am already kind of planting a kind of a cultural lens on it and how much of that is kind of specific to language, I don’t know.” While this clinician acknowledges taking cultural values into consideration when working with Spanish-speaking clients, he neglects to acknowledge that even work with Anglo American clients involves cultural values. Viewing work with Anglo American clients as culturally ‘neutral’ sets up work with Latina/o clients to be viewed as outside of the ‘neutral’ lens of Anglo American culture.

More directive. On the other hand, one participant noted being more directive in her work with Spanish-speaking clients:

I'm like a little more directive...taking on the role of the professional, it's a little less collaborative ...Um but in some ways it's like that's what some patients expect or they respond well to that or that feels containing to them...sometimes I feel like I'm like channeling these older women that I knew in Chile and Argentina and I'm like, "what are you doing??" And it's just like I don't have a lot of access to that in English.

Clinician behavioral differences. Five participants reported differences in their behavior when working with Spanish-speaking patients. This same clinician reported that she engages in more self-disclosure regarding familial struggles with disabilities when working with Spanish-speaking clients “because I think it’s helpful to see that like everybody has some issues, you know...and really it helps me kind of join with them.”

Another participant noted, “When I’m seeing a Spanish-speaking client, especially female, I try to wear more color. [Laughter] Because they-, I don’t know, they’ve commented on my color.” One participant noted that he experiences more physical contact when working with older Spanish-speaking women.

Another clinician noted that he engages in more discussion regarding family events, and at times even requests to see photos of recent events patients have discussed noting “I know I end up talking much more about family parties and are they looking forward to it or I will ask to see photos of family events and I will be like “*Ooo, ¡Qué linda!* (Oh, how pretty!).”

This participant also discussed having more interactions with Spanish-speaking parents of patients in the waiting room ", in a way which I would not necessarily with some of the English speaking parents who I kind of more assume might be like happier to hide behind their Kindle or whatever it is they are doing. You know, I am a little bit more discrete with them in a way.” He then observed that for the local Spanish-speaking patients, the hospital plays a large role in the community and their family’s lives:

They've had their babies here, they live within five blocks, it is just kind of a part of the fabric and we are part of that as well...versus a family who might be coming in from further away for a specific treatment or something and it is just a slightly different relationship with the clinic and hence the clinicians. And I mean lower SES versus higher SES and all of that sort of thing, I would say that mostly our Spanish speaking population fall in the lower SES proportion of the client population.

As illustrated by this participant, language is but one factor that determines interactions between clinicians and clients, the greater context of a client includes many more factors, including their social surroundings, their economic status, their legal status, religious, and their ethnic identity.

Differences in clinician cognitive experience. This same clinician also discussed a number of ways that his emotional and psychological experience of working in Spanish differs from working in English. He discussed a sense of working in Spanish as “in some ways more rewarding...knowing that there’s so few people out there that are offering this service, and that we as a clinic are able to provide it, at least in some form. So, in some ways it actually is much more rewarding, albeit more tiring.” This comment that he finds it more tiring to work in Spanish, is a sentiment echoed by five participants (including the clinician referred to above) in different ways.

More focus required working in Spanish. Two clinicians specifically observed that working in Spanish requires a higher level of attention to ensure they do not become lost in the conversation. One of them noted “if I miss a sentence or two, it will take me a lot longer to catch up to figure out where we’re going, than obviously if it was in English...the focus really needs to be there; the attentiveness needs to be there.” Another clinician suggested that she is less likely to doze or daydream when working with Spanish-speaking clients due to the increased focus required.

“I never do that with my Spanish clients because I really feel like I’m
‘on’...I’m more aware that I have to be really careful, you know, with what I
say and how I say it and make sure it’s understood properly. And not talk too

much, you know... then there's also you know just being careful the way I phrase things"

More tiring. Five clinicians identified working in Spanish as more tiring physically and/ mentally. One clinician noted that working in Spanish can be tiring as speaking in Spanish is not an everyday activity for her "It's exhausting for me, because we don't live in a place where I can practice Spanish all the time." Another clinician noted that he takes into account working in Spanish requiring more energy when scheduling clients: "I try not to see Spanish-speaking clients late at night because I'm tired [laughs]. I have to work harder because it's not my native language, and so I have to think more how to say things." Another clinician who discussed finding working in Spanish tiring clarified "mentally more than anything...at the end you just feel a little bit more physically exhausted because of the mental fatigue."

Therapy in Spanish is less smooth. Another clinician noted that providing therapy in Spanish is not as "smooth" as when he works in English:

I feel like in English it goes more smoothly. For example, here, we do a lot of evidence-based practices. So, whether it's CBT, DBT, or interpersonal psychotherapy for adolescents, I have a lot of the metaphors down in English. I have scripts for working with socially anxious kids or selectively mute kids or this and that. And I've worked with so many in English that the script is there and obviously the language capability is there. So, it doesn't always run as smoothly in Spanish, which is unfortunate."

This clinician then goes on to express a belief that this lack of fluidity in providing services in Spanish is “part of the risk-benefits of having somebody who’s not fully fluent...Do you give them therapy that doesn't run as smoothly, or do you give them therapy with an interpreter.... or put them on the wait list?”

Demonstrating one method of coping with a relative lack of fluidity in providing services in Spanish, another participant often engages in more thorough planning of sessions when having joint sessions with Spanish-speaking family members:

I’m kind of looking for clarity in terms of the three or four points that I want a family to be aware of at the end of a session or like the interventions that we have in mind or take homes to take away. I think that I tend to kind of formulate those a little bit more formally in my head before, if I say have a Spanish-speaking parent coming in for a collateral [session]. I am like okay, ‘what are the two or three things that we’ve been working on that I really think it’s important that I convey here?’”

I’m maybe slightly less relaxed on the inside...probably I'm more worried about my abilities as a therapist when I'm doing it in Spanish... that's probably a thought in the back of my mind.

A couple participants expressed greater concern regarding being understood when working in Spanish, and one participant addresses this with greater focus on her non-verbal communication.

A little bit more expressive than in therapy in English...so I make it really clear, we do a lot of facial expressions ... make sure that they're really understanding what I'm saying.

It's concerning that none of the clinicians expressing difficulty providing fluid therapy in Spanish described experience using treatment manuals adapted for working with Spanish-speaking clients. While culturally-tailored and validated therapy for Spanish-speaking clients still has a way to go (Guarnaccia, Martinez, and Acosta, 2002), a range of treatments have been adapted for Spanish-speaking clients including limited psychoeducation for families (Hackethal et al, 2013) and the most widely publicized and researched adaptation at this time is cognitive-behavioral therapy for depression (Organista and Muñoz, 1996).

Clinician emotional experience. When asked, clinicians discussed a range of emotional experience when working in Spanish. Two participants discussed experiencing equal emotional impact of discussions whether working in English or Spanish, while a third participant reported that when she first began providing therapy in Spanish, she "wouldn't respond as affectively to it," but noted that this no longer occurs and decreased significantly after spending a significant period of time living abroad in a Spanish-speaking country.

Spanish viewed positively albeit exotic. Three participants reported experiencing working in Spanish as more emotionally evocative and expressive than English. One person noted, "...there is inherently an emotional content in Spanish that I don't find as much in English and-and I don't know if that's objectively true [or] if that's just my perception because I may idealize the other language. But there's a colorfulness to the

phrasing and the words that are used that I think can be more emotionally evocative.”

Another participant noted “the ability of Spanish to express things certain ways, is more poetic, more flowery almost... ‘Cause I do know a lot of the metaphors and the deeper ways to express things in Spanish has a certain beauty to it... in a way it’s more alive. That’s a huge generalization, but more organic, more alive.” Similarly, another participant noted “I definitely feel like I make more of an emotional connection to them [Spanish-speaking clients]” and even noted experiencing “warm fuzzy feelings about them.” Another clinician believes therapeutic rapport develops quicker when working with Spanish-speaking clients reporting, “You just kind of make, I think, a quicker connection.” She noted “Non-Spanish speakers come to therapy and there's always this ambivalence about, 'How much do I reveal?' With Spanish-speaking clients there's more transparency, more genuineness. You're not guessing at what the other person is thinking or feeling as much.”

More interest in and need for supportive psychotherapy. Two participants expressed the belief that CBT is less effective with Spanish-speaking clients which contributes to the majority of their work with Spanish-speaking clients being “more supportive.” One of them noted “I don’t use any clinical terms...it’s a lot of supportive psychoeducational work...it’s really rare that I go further...most of my [Spanish-speaking] clients that’s not their orientation...they really just need the support and education.” This belief that CBT is less effective with Spanish-speaking clients does not appear to be based in literature as far as participants noted, and is important to recognize as an unexamined stereotype.

Language is contextual.***Socioeconomic status impacts language and life experiences.***

I think the stressors are different on Spanish-speaking clients living in this country.... that might be partly [because] most of the Spanish-speaking people I've worked with have been lower income.

A number of participants discussed the confluence of language, culture, education, and socioeconomic status when reflecting on their experience of working with Spanish-speaking clients:

A lot of my English-speaking patients can be very intellectualized so the intellectual use of language is a defense against the emotional expression ... and I think that's a culture, there's just a cultural difference, there's a class difference, so there's just I think, maybe were I working with Latina/o Ph.D. students in Spanish I might, I might have seen more intellectualized defenses.

Immigration status creates significant stressors on families. While a number of participants alluded to working with undocumented clients, only one participant noted addressing it as a focus of treatment. When undocumented parents express concern regarding deportation he works with the parents to access and use family planning guides to better prepare for possible deportation.

Language vs. culture. While language may impact work with Spanish-speaking clients; it is not the sole factor impacting the work together. This raises the question of the meaningfulness of distinguishing between language and culture, as language is often interpreted as being one aspect of culture, rather than a discrete concept or entity. A number of participants reflected on the relative place of language in the greater context of

clients:

Whatever differences there were had less to do with the language and more to do with the culture and the population and other variables...probably on some unconscious level I was [making accommodations] and it had more to do with what I was able to say versus what I wasn't able to say, but less to do with the theory or what I was trying to accomplish with the patient.

Another clinician stated that,

The kind of work you're doing with a person just has a lot more to do with who they are, what they're coming in for, what their struggles are, the kind of - and this is also very individual, their capacity for insight versus needing to do more concrete work or supportive work.

Both clinicians demonstrate the central difficulty in this study, which is whether one should distinguish the impact of language from that of culture, socioeconomic status, ethnicity, and all other factors impacting therapy and assessment. In exploring and recognizing the importance of one variable in a client's life, language, it is important that we not let ourselves be blinded to the many other aspects of their life.

Chapter VII: Working with Spanish-English Bilingual Clients

While many questions focused on the experience of working with monolingual clients, eleven participants also worked with Spanish-English/English-Spanish bilingual individuals.

Working with Mixed Bilingual Families

More than half (7) of participants shared experiences working with mixed bilingual families. Mixed bilingual families for the purpose of this study are considered families wherein children speak predominantly English while the parents primarily speak Spanish. Clinicians noted multiple methods of bridging the linguistic divide when conducting family sessions. Some clinicians noted switching languages and addressing each family member in the language with which they are most comfortable:

Yesterday a mother came in and said (in Spanish), “we’ve been working on anxiety a lot but there was this incident yesterday where he was really angry and out of control and he didn’t want to do what he’s told,” and I turned to the kid and said, “tell me what happened.” He’ll say a few words in English and I’ll say back to them, okay “Okay, *eso parece un asunto muy importante y vamos a trabajar sobre eso en las sesiones que vienen* (Okay, that seems to be a very important issue and we are going to work on that in the coming sessions).” Something like that, you know? So I will kind of loop it back but in those moments of trying to connect back to the kid I will typically switch back to the English for a minute and then bring it back to what we are going to do in Spanish.

While this requires skillful bilingual interactions on the part of the clinician, it has the benefit of engaging with each person in the language they most fully understand.

To promote fluidity of interaction, one participant attends to Spanish-dominant parents' understanding when interactions are in English, interpreting only when necessary.

Improving ability to communicate within mixed bilingual families arose as a focus in sessions when participants work with split bilingual families. Four participants seek to help English dominant children better express themselves to their parents in Spanish while in session. This may take the form of encouragement and help translating the child's ideas if necessary. Another approach to working with mixed bilingual families with significant obstacles to communication involved focusing on non-verbal cues to help parents confirm that they understand what their children need to communicate.

Language choice by clinician. While most clinicians discussed their ability to speak Spanish when working with bilingual families, one clinician notably chose not to do so, in consultation with his supervisor, based on multiple factors. This clinician noted their intention behind the decision:

Early on in the treatment as a way of kind of, um, kind of putting a little bit of a dampener on some of their arguments, I and my supervisor who speaks Spanish actually, he's an English, predominantly English speaking guy who speaks Spanish, thought 'let's do this as an English therapy' in order to have a situation where I felt kind of on top of my game because they are a couple that involve a lot of kind of close management, or require a lot of close management, and also almost as a way of helping them create a little bit of emotional distance."

Code-switching

Participants with experience working with bilingual clients experienced varying levels of code-switching between Spanish and English. While participants noted bilingual clients freely code-switching back and forth rapidly can be “quite a linguistic ride,” others focused on the added difficulty introduced by clients code-switching rapidly. One participant noted that following the code-switching of a client is “hard to do, because they’ll start off, and in mid sentence, they’re in the other language; and then they go back to the first language.”

It takes a lot of flexibility on my part and again flexibility and a lot of attentiveness and just energy, energy from me to be very engaged and ready at any time for the person to switch into another language and for me to be able to understand.

Participants emphasized the added energy, flexibility and attention that is required of a clinician when a client is code-switching, which it must be noted is in addition to the increased focus participants had noted they expend when working in Spanish. Clinicians occasionally experienced a delay in their own mental code-switching acknowledging “there’s been a couple of times where it takes me a second to realize that they even just switched into another language because it happens so quickly.” This is likely due to the sense that clinicians may find themselves in a language-specific “zone” of sorts when they are working in Spanish. Through working with clients and friends who code switch, clinicians increased their flexibility and speed of code-switching over time. Further research into what activities are best for improving one’s code-switching skill would be useful for training bilingual clinicians.

Functions of code-switching. Depending on the situation, code-switching can serve to clarify or obfuscate the meaning and sentiment of a person's communication. Increasing the impact of communication is one reported reason for code-switching whether by clients or clinicians. This may take the form of using words that convey the precise meaning desired, or metaphors that exist in one language but not another. Participants noted that whether intended by clients or not, code-switching serves to provide additional emphasis to any concept expressed after the code switch occurred.

Other times clients may switch languages to discuss experiences in the language in which they occurred for ease of communication as well as language congruity. In the words of one participant this enables client and clinician to "work with that material more directly." Yet this same participant acknowledged that speaking Spanish is often specific to certain relationships in a client's life which plays itself out in session by Spanish only being used to discuss certain people or certain relationships while English may be used by a client to discuss other topics with less emotional weight.

Similarly, a clinician may switch into English or Spanish to ensure that both parties are fully understanding each other, whether to clarify a word, how to say a word in English, or to explain a concept in Spanish.

Therapeutic meaning of code-switching. One participant explored the range of implications inherent in a bilingual client's decision to code switch from Spanish to English. The participant labeled this choice as noteworthy as the entire course of therapy up to that moment had been conducted in English:

It was clinically significant, because some people who've had like traumatic experiences in one language when they speak the other language, they cannot

access the affect as directly as one, if they're speaking the original language. So I'm like 'oh she's speaking the original language'...I think that that was a sign she was getting closer to me, a sign of trust.

Recognizing that speaking in a secondary language reduced the intensity of affect, one participant interpreted a bilingual client's decision to speak in Spanish for the first time as a sign of increased intimacy in the clinician-client relationship and "a sign that she was trusting me more and she was able to talk about really difficult aspect of her past that she hadn't talked about before."

Code-switching as a shield. Code-switching may also be used consciously or not, to either reduce the impact of a topic of discussion or hide the meaning altogether. A number of participants' clients were noted for using code-switching as possible defense against intense affect as first posited by Greenson (1950) and later expanded upon by Marcos (1976a). Other participants perceived code-switching as an intentional or incidental defense against the outside world for a variety of reasons, one which can be used by clients as a protective shield from unwanted intrusion.

One guy with PTSD who really didn't want to talk about what was going on and really pretending not to understand a lot of my questions or misunderstanding or kind of barking back at me in ways that made it very difficult to respond. So I think if you are getting close to somebody who's highly avoidant or a situation where a personality disorder is part of their makeup, language can create much more of an obstruction.

Another defensive use of code-switching was noted by a clinician who had worked on an inpatient unit with a bilingual woman who experienced

paranoia and would switch into Spanish when saying something she did not want overheard by others.

No impact or a positive impact. Participants shared a wide range of feelings about the impact of code-switching. While one participant noted “I don’t think it’s having any kind of an impact,” other participants expressed beliefs that it greatly expands the clinically relevant and informative body of knowledge available to them. Multiple participants reflected on the richness of information and therapeutic dynamics that can be explored by attending to a client’s choice of language:

I think that there’s a way that it makes the therapy richer in some ways, because that language, that different language is connected to different cultural aspects of that person’s life. For instance, they speak French, they speak Spanish, they speak you know German, they’re connected to things that are parts of themselves that I think makes for a richer exploration of what that means to them, and how that affects the person that they are. I do believe that there’s parts of a person’s experience that are sort of stored within that language, like early childhood experiences if the person grew up in a monolingual Spanish-speaking home. You know, parts of that, when we switch into Spanish, parts of that sort of ignite a little bit more, to just be able to explore all those things that...I won’t say that I wouldn’t explore them with a solely English speaking person but I think it provides for a more complex, dynamic, rich exploration.

Another participant noted working with more experienced clinicians assisted her in recognizing the various layers to think about when working with bilingual clients:

I was working with some people who were also bilingual so they had the choice to speak Spanish or English which is a whole other layer of thinking when you're interacting with someone clinically, so it's not only about how I use the language and the anxieties that I have about the language, it's also about you know their choices about the language to use and when they decide they want to speak to me in English versus Spanish, how they make that choice, how they view me, you know as a person who could understand them versus their wanting to be competent in their second language. So there's all kinds of dynamics that I think were starting to become more apparent to me as I was talking with people who were more experienced.

Another clinician reflected on differences in language choice between two of her Spanish-speaking clients:

This is the other woman, she doesn't ask, she knows I understand and when she's describing an interaction with somebody who spoke Spanish to her she just says it, she doesn't indicate that there's a question about whether I understood what she said, she just...says it. So I think, that's the benefit of having a collection of people you're doing this work with, because it really does say something about their dynamics, right? So with this guy, he asks my permission to switch into Spanish, he likes to ask me what the words are, so you know it says something about how he views me as an authority. I'm actually really enjoying having the opportunity to really think this through. I think there's lots of layers to this that I haven't actually totally thought about. This may prompt some additional questions with him in the next session, like why he feels like he has to ask me for

permission about that. I think he may view me as maybe more of a parental authority figure and that's an important piece of information.

Through a close examination of the clients' interpersonal interactions with her, and their choices around code-switching, this participant has begun to more fully grasp her clients' dynamics while participating in this study.

By viewing code-switching not as confusing or random, but acknowledging the possible motivations, albeit subconscious at times, it can be valued as an activity which contains vital clinical information.

Chapter VIII: Organizational Context and Experiences

Reception by Latina/o Colleagues

Participants reported a range of experiences regarding their reception by Latina/o colleagues as non-Latina/o Spanish-speaking clinicians. Almost all participants (10) regarded experiencing an unqualified positive reception by Latina/o colleagues. One clinician noted that she currently feels accepted and deemed competent by Latina colleagues but initially struggled to gain acceptance as a European American Spanish-speaking clinician. Another participant reported feeling that despite various negative responses she believes that a “majority of people” are “outwardly appreciative” of her efforts to provide therapy to Spanish-speaking clients.

Negative reception. As noted above most participants discussed being positively received by Latina/o clinicians. Three participants reported being poorly received by Latina/o colleagues and clinicians in varying places, although one such participant had previously reported her reception as entirely positive. One clinician initially faced resistance and skepticism from her bilingual bicultural Latina/o colleagues as a result of early comments seen as insensitive. This clinician noted that despite initial friction, she feels confident that over time she has been successful establishing her credibility, assisted in her task by a Puerto Rican colleague and higher up who has always supported her Spanish ability. Another participant reported that one of the sites she worked at her experience was of a “mostly positive (reception) but there was sort of feeling like because I was white, they were just going to give me whoever.”

A third participant reported being poorly received by Latina/o colleagues at professional events although she does not work with any Latina/o colleagues in her

current position. It is important to recognize that this participant acknowledged very conflicted emotions regarding potentially working alongside Latina/o colleagues in the future. She acknowledged that when imagining possibly working with Latina/o colleagues, “part of me was thinking I really like the fact that there aren’t other Latina social workers.... I developed my own confidence doing therapy in Spanish...I don’t want to be compared to somebody who’s Latina.” At the same time this clinician acknowledged that she would benefit from having a bilingual bicultural supervisor.

This clinician noted that she feels she has to defend her choice to work with Latina/o and Spanish-speaking clients, “I feel like I defend myself a lot...”, and shared strong reactions to being asked about her motivation.

Factors exacerbating conflict. It is important to recognize that while this participant reports negative reception by Latina/o colleagues, her reactions may become colored by this experience. She noted, “I think it’s kind of unfair Because bottom line, they can’t find anybody else. So, you’re lucky I’m doing it.... I don’t say I’m Latina I’m not selling myself to be somebody I’m not, but I’m helping the community.” The sentiment that Latina/o colleagues are “lucky I’m doing it” which appears to invalidate or deprive one’s Latina/o colleagues of their opinions regarding a non-Latina/o clinician’s work does not bode well for a clinician’s openness to self-examination in work with Latina/o clients. Furthermore, it conveys a sense of entitlement that by working with Spanish-speaking clients one should be given a ‘pass’ on criticism. This suggests additional efforts to explore her attitudes regarding her motivation and reception by others would benefit herself and her work with patients.

Curiosity expressed about motivation. While the previous participant experienced questions regarding her motivation as attacking, two participants reported being asked about their motivation in a positive and supportive manner. One clinician noted that when speaking with Latina/o colleagues he believes “there’s this thought of, “- Why does this gringo want to do this?” And it’s not any paranoid, malicious thought, I think it’s more of an appreciation that I enjoy the culture and this is something that I wanted to do.” Another participant noted that upon meeting new Latina/o colleagues she experiences curiosity and questions about her motivation and how she developed her skills, followed by “a lot of positive reinforcement for how great it is that I am interested in helping Latina/os and giving me a lot of positive feedback for it.”

Institutional-level Support

Participants reported a wide range of institutional support at the various organizations at which they worked. Some participants noted that the organization they worked in offered little to no meaningful support. One participant noted that while they technically have the support in the form of grand rounds on culturally relevant topics, the grand rounds are consistently scheduled at a time which is incompatible with their department’s regular schedules.

Verbal encouragement. Many participants discussed the majority of support being in the form of verbal and systemic encouragement. At times this was seen in a suggestion for a group for Spanish-speakers being “very much embraced.”

Shallow depth of commitment. While other participants discussed receiving verbal encouragement of the form of “Have a go, we trust you, we think you will do great.” At the same time, some organizations appeared to call into question the true

depth or purpose of their provision of Spanish-language services by seeking to hire Spanish-speaking clinicians but demonstrating no care for ascertaining the quality of a clinician's Spanish fluency or clinical skills instead brushing aside the need to determine a clinician's ability with a "they're fine, I'm sure."

One clinician, hired on at a private group practice for the express purpose of the group practice being able to offer Spanish-speaking clinical services found herself facing obstacles of an English-only infrastructure. She noted that the office receptionist speaks English only and as a result her clients dislike calling the main office. At their request, she provides her cell phone number to circumvent the difficulty of communicating with the English-speaking receptionist. Despite the structural choices made by the group practice members that create this situation, she feels challenged by co-workers who ask her about the decision to provide her cell phone number. In response, she states "this is something I do with these clients because I think it's a way of building rapport, it's a way of making it a little bit easier for them to communicate with me." The English-only nature of the clinic extended to both clinic forms and administrative staff which contributed to the clinician's workload as she assisted all monolingual clients in completing the initial intake form, and often provided her personal phone number so clients could reach a Spanish-speaking person to leave messages.

Yet even when in a Spanish-only setting, one participant observed that not all staff were fluent in Spanish although the participant was careful to note, "I think that they're doing the best that they can." Another participant perhaps said it best regarding current training available for Spanish-speaking trainees when they said, "...systems are not

always set up...in an administrative way, or supervisory kind of way to support the clinicians or trainees who are coming in who can provide the services in Spanish.”

Further study of the rationale and ethical complexities behind programs advertising that they provide services for Spanish-speaking clients without proper support or linguistic knowledge appears necessary. In order to better support clinicians and the patients they serve, we must understand what contributes to linguistically insufficient staff and clinical support persons. Additionally, it is important to explore the potential for ethical concerns if clinics are insufficiently assessing the clinicians and paraprofessional staff they hire to work with Spanish-speaking clients. To truly provide effective treatment to Spanish-speaking clients, Spanish-speaking clinics must hire support staff who are fluent in both speaking, writing and, ideally, translating English and Spanish. By doing so clinicians will be able to focus their efforts on providing clinical services, and clients will no longer be marginalized by the very clinics that purport to welcome and serve them.

Inconsistent support. Other clinicians reported receiving mixed messages of support from their employers. One organization provided all clinic paperwork in Spanish except letters sent to parents had to be translated by clinicians on a case-by-case basis. This same clinic provided no treatment materials in Spanish for use with Spanish-speaking clients which meant that any treatment manuals had to also be translated by clinicians. Yet another signal that Spanish-speaking services were not the top priority could be seen in a reduction of in-person interpreters although the clinic still offered telephonic interpreters.

Another participant noted that she received support through both Spanish-speaking administrative staff and being given leeway with her schedule to enable attendance at a Spanish language class as well as financial support in the form of tuition remission. Two participants noted being provided with financial support in the form of purchases of testing materials in Spanish as needed.

Those participants who reported having received the most support for Spanish-language service provision were those who had worked at clinics specializing in providing services to Latina/o and/or Spanish-speaking clients. Some participants noted receiving supervision from Spanish-speaking clinicians at their clinic, while others had the experience of Spanish-speaking supervisors being brought in from other clinics to supervise them. It is important to note that some participants reported that these supervisors provided them with significant support regarding cultural aspects of working with Spanish-speaking clients yet desired more support on issues specific to working in Spanish.

Two participants noted that when training they received supervision involving discussion of linguistic issues as well as cultural issues in the form of guidance regarding vocabulary usage in testing and therapy.

Official identification of bilingual ability. One participant expressed that the true sign of institutional support came from receiving institutional testing and acknowledgement of her Spanish-English bilingual fluency on her ID badge. This is an important demonstration of how an organization may fully demonstrate and emphasize both dedication to and support for providing high quality Spanish-speaking services.

Chapter IX: Assessment of Spanish-speaking Clients

Clinician Experience Providing Assessment

Over half of the participants (7) explored their experience conducting psychological assessments of Spanish-speaking clients. While the study focused primarily on participant's experience conducting therapy, three of the participants currently or predominantly work conducting neuropsychological assessments or forensic evaluations for a variety of purposes. Clinician's reported a number of differences in their experience of evaluating Spanish-speaking clients. One participant reported feeling more curiosity and openness when assessing Spanish-speaking clients, as well as being "less jaded" when assessing Spanish-speaking clients.

Assessment in Spanish requires greater effort. Another difference noted by three participants, that echoes the experience of clinicians conducting therapy in Spanish which is "it's more effort than testing somebody in English" while two other participants noted feeling tense, anxious, and nervous due to the added effort of testing Spanish-speaking clients. One of the participants reported that when she first began conducting evaluations in Spanish she had difficulty anticipating when a client's line of conversation was becoming tangential.

Difficulty determining source of communication difficulties. Another participant noted that they have more difficulty assessing sources of communication difficulties which arise while testing Spanish-speaking clients noting,

I find that it's easier to tell with the English-speaking clients whether it's due to some defect in the way that I phrased the question or the comment as opposed to the person's cognitive limitation or their attentional problems, or lack of reality

testing. With a Spanish speaker, it's harder to differentiate.”

One participant who received a significant level of higher education in Spanish noted that she has found it very important to have “higher level thinking or training in Spanish and not just street Spanish.” Another participant noted that while lacking Spanish-speaking colleagues at her current place of employment, she felt comfortable consulting with cross-culturally competent English-speaking colleagues regarding “I’m seeing this pattern on testing, you know. Do you think this could be from, from someone who doesn't understand how to do this?’ You know, and they have a lot of things to say more generally about, you know, the cultural effects on testing.”

Being “the” Spanish-speaking assessment provider. One participant noted that as she is the sole clinician at her location conducting assessments in Spanish, she lacks anyone to consult with on clinical decisions regarding assessment of Spanish-speakers.

Differences and Modifications when Testing Spanish-Speaking Clients

Evaluation as investigation for monolingual parents. A clinician who conducts forensic evaluations of child abuse allegations noted experience serving as a clinical detective for monolingual Spanish-speaking parents. She noted asking a Spanish-speaking parent, “Why is your son having an evaluation?” and being told, “Cause I want to find out what happened.” This experience of split bilingual families utilizing bilingual clinician’s as a bridge between them and their children is a theme that also arose in discussions of therapy with split bilingual families.

Assessing educational level of clients. Another major difficulty reported by clinicians conducting evaluations of Spanish-speakers pertains to the educational level of Spanish-speaking clients. A number of clinicians reported that they had difficulty with

finding measures adequate given clients' level of education. One participant reported that when her clients have difficulty understanding words on self-report measures normed at a 5th grade reading level she often resolves it by offering alternate words noting that clients at times do not understand terms such as "*expectativas* (expectations)."

Adjusting sophistication of Spanish to clients' educational level. Another participant reported having difficulty "adjusting the level of sophistication of my Spanish" noting that when working with highly educated clients of higher socioeconomic status, he wishes he "were able to speak a more nuanced Spanish; but most of my Spanish speakers, no problem. It's pretty concrete with them...if I'm too sophisticated in my use of language, they, they need toning down of the level."

Spanish-measures are less well developed than English measures. Overall, a number of participants agreed that while a number of measures are available for Spanish evaluations, a number of the measures available are less well developed than measures available in English. One participant reported that when screening a client's reading level in English, they will use the WRAT reading section as a "quick and dirty screening" noting "there's nothing that exists like that in Spanish, so I use something called the Reading Level Indicator Spanish Companion, which is a Spanish-language form of an English test that's self-administered, and it doesn't go much below third grade." This participant discussed norming flaws in the original EIWA noting that they contributed to inaccurate standardized scores for Spanish-speaking clients and caused difficulties using the original EIWA in forensic settings.

As assessment was not the primary focus of this study, interview questions did not explore specific measures in greater depth except when noted by participants.

Implicit values of neuropsychological testing. Regarding neuropsychological testing specifically, one participant reported a number of differences specific to subsets of Spanish-speaking clients. Interestingly, the participant reported that she found that “women who are a little older, 50s, 60s, with depression and anxiety...who fail effort testing.” As a result, she noted “I have altered how I explain testing, what the process is, what we’re looking for, what I need from them. I’ve altered it many times to try to find a way to get best effort from this one particular kind of group of people I see. It makes sense to me, because I think women of that age group and background, you don’t go to the doctor to show what you can do, you go to the doctor to show what you can’t do.”

This participant noted that amongst Spanish-speaking clients, “there’s often less familiarity...testing is a lot like school in the States, and if you haven’t gone to school in the States, you’re a lot less familiar-- with the kinds of things you’re asked to do.” This lack of familiarity is clear when the same participant notes that Spanish-speakers “struggle with... ‘if you want me to go fast then it’s not going to be good, or accurate. If you want it to be accurate, and my best work, then it’s not going to be fast.’ So the value that our culture, or the dominant culture has placed on speed and time is hard to communicate, and always a factor in testing.”

Another participant reported that she finds neuropsychological testing easier to conduct than providing therapy as “it’s more scripted” but noted it requires “being more prepared” and that as a result she is “a bit more thorough” when asking questions of clients.

State of Spanish-language assessment. Two participants reflected on the perceived state of assessment of Spanish-speaking clients. One observed “I feel like, what we’re doing with Spanish-speaking populations, some of it’s great and advanced and sophisticated, but so much of it is much more elementary.” Similarly, another participant briefly referenced his own research noting “in my research which involves using measures that have been used with Spanish speakers...a lot of it is about...whether or not assessment is sensitive to the mental health needs of Hispanic families and oftentimes it isn’t.” In order to ensure accurate, culturally and linguistically relevant, and competent assessment, it is vital that increased efforts and focus be given to development and norming of Spanish-language assessment measures, as well as brief measures to assess the linguistic proficiency of clients in Spanish and English.

Chapter X: Discussion, Recommendations, and Conclusion

Past research on bilingual mental health practitioners largely focused on the experience of Latina/o clinicians providing clinical services to Spanish-speaking Latina/o clients (Castaño et al, 2007; Verdinelli & Biever, 2009a, 2009b), until Verdinelli & Biever (2013) began to explore the experience of therapists' providing cross-ethnic therapy with Spanish-speaking Latina/o clients. A number of themes noted by clinicians in this study are similar to ones noted in Verdinelli and Biever's study (2013), and in past studies that focused on Latina/o clinicians working with Spanish-speaking clients (Castaño et al, 2007; Verdinelli & Biever, 2009a, 2009b).

Themes that arose during this study can be broken down into five main categories: development of Spanish language competency, training received to provide clinical services to Spanish-speaking clients, experience providing clinical services, systemic and institutional impact on experience working with Spanish-speaking clients, and recommendations.

Linguistic Competency Development

Motivation to work in Spanish. Participants in the current study noted becoming motivated due to 1) personal connections to Latina/os; 2) immersion experiences including studying and/or working abroad; 3) recognition of influx of Latina/os to US; and 4) career benefits. Similar to the participants in this study, the 2013 study by Verdinelli and Biever noted that most participants were proficient in Spanish prior to becoming bilingual therapists. Motivation for working with Spanish-speaking clients was seen to be similar to that of clinicians of past studies (Verdinelli & Biever, 2013). Similar to Verdinelli and Biever, 2013, participants noted that experiences living abroad,

personal interactions with Spanish-speaking people, and genuine interest in other cultures contributed to their decision to learn Spanish. Additionally, participants in Verdinelli and Biever (2013) often chose to use their Spanish proficiency as they recognized how useful it would be in their career. The lack of Spanish-speaking clinicians was found to contribute to their decisions to utilize their bilingual skills in clinical settings.

Methods to learn Spanish. While past studies have explored the Spanish learning experience (Verdinelli and Biever, 2009a; 2013), only Verdinelli and Biever (2013) addressed the Spanish learning of non-Latina/o clinicians. The main methods used to learn Spanish were formal language classes and immersion experiences in Spanish-speaking countries (Verdinelli and Biever, 2013). Participants in this study employed similar methods while developing their Spanish competency: formal language classes in secondary school, and immersion experiences in a Spanish-speaking country. While formal learning was the most noted method for developing Spanish fluency, informal means were also emphasized as key to continual development of Spanish proficiency, demonstrating application of the suggestions of Latina/o clinicians from a past study (Castaño, 2007; Verdinelli and Biever, 2009a) who advised daily use of audiovisual media to improve proficiency. Similarly, the participants in this study also reported Spanish development through 1) consumption of written and audiovisual Spanish-language media, 2) language software (e.g., Rosetta Stone), and 3) socializing with others in Spanish. It is important to note that participants in the current study were in agreement with the Latina/o clinicians of Castaño's study (2007) as they also discussed development of Spanish competency as an ongoing process. The reality that developing and

maintaining Spanish language competency is an ongoing process, is vital for training programs to acknowledge and support.

Learning professional Spanish. While speaking Spanish is often regarded as the key skill for providing clinical services in Spanish, it is important to note that speech alone does not allow a clinician to provide competent services in Spanish. Working in Spanish requires that clinicians develop professional knowledge in Spanish as well as cultural knowledge. In order to educate both clients and oneself on issues of mental health, it is vital that a clinician learn clinical terminology in Spanish as well as terminology to discuss mental health and mental illness at the appropriate level based on individual clients' education. When not provided by one's training program, bilingual clinicians often find themselves struggling to learn and express clinical concepts in Spanish (Castaño et al, 2007).

In order to research and utilize resources, Spanish literacy is vital; and to provide clients with educational material and often even clinic forms in Spanish, writing, and ideally some experience with translation are vital for clinicians. As noted in past studies (Castaño et al., 2007; Engstrom and Min, 2004) translating and communicating using clinical language is a particular area of difficulty for bilingual clinicians as the majority of training tends to take place in English. It is important that agencies hiring clinicians to work with Spanish-speakers ensure clinicians are capable of using multiple modalities of communication in Spanish. As noted by bilingual social workers (Engstrom and Min, 2004) and psychologists (Castaño et al, 2007) the workload of clinicians providing services to Spanish-speaking clients is greater than clinicians working with English-speaking clients only. It is important that agencies and training programs recognize this

and provide the necessary support and accommodations to clinicians. Given the range of skills often utilized in providing services in Spanish, it is apparent that Spanish proficiency must be recognized to be a continual, and indeed life-long process often relying on Spanish language media, and informal socializing in Spanish.

More than just translation into Spanish. As one participant noted providing clinical services to Spanish-speaking clients is “more than a matter of translation.” Translating the substance and style of mental health services in the US into Spanish is acknowledging the linguistic differences while ignoring all other differences between the predominantly European American population of the US, and the predominantly Latin American Spanish-speaking population of the US.

As there is no such thing as a typical Latina/o/Hispanic it is important that clinicians become comfortable not only studying the regional and national differences but also recognizing how differences in socioeconomic status, religious and spiritual beliefs, educational attainment, and gender and sexuality impact a client’s experience. By acknowledging to themselves and their clients when they are unfamiliar with a topic, clinicians will help to acknowledge and fill the gaps in their knowledge base, a key skill when working in Spanish.

Clinical Competency Development

A continual process. Throughout the study, competency development clearly involved clinicians continually seeking to improve and expand upon their knowledge and experience. Providing clinical services in Spanish requires two inter-related bodies of knowledge and skill sets: 1) how to provide culturally competent services in Spanish and English tailored to the client’s identity; and 2) how to focus inward and explore their own

values, cultural beliefs, and biases, and linguistic experience and the impact of these factors on their cross-cultural work.

Lack of formal training. One theme that appeared in this study as well as past studies (Castaño et al, 2007; Verdinelli and Biever, 2009a) regarding provision of mental health services to Spanish-speaking Latina/os is the lack of formal training to provide services in Spanish. One key reality, not identified in past studies, arose when three of the clinicians who had not received formal training explicitly expressed a belief that no such training exists. While the relative lack of formal training is a repeated issue, there are a number of programs that offer training specific to working with bilingual Latina/o clients (Pacific University-Oregon, Our Lady of the Lake University, Massachusetts School of Professional Psychology). The lack of awareness of existing training programs suggests that in order to be truly useful, both programs and clinicians in the field would be advised to support greater public awareness of training. This lack of awareness of training available is an important factor to further explore in future research.

Those who did receive formal training noted that such training included cultural competency training in parallel with Spanish language training, but not formal training on the intersection of Spanish language and providing mental health services to Spanish-speaking Latina/o clients. It is important to note that Our Lady of the Lake University's Psychological Services for Spanish Speakers program states on its website that the majority of its core courses are offered in Spanish or Spanish/English. This program may serve as a guide for future programs, not only training clinicians in Spanish and psychological thought, but to train them in psychological thought in Spanish.

Clinical experiences in Spanish are vital. The experience of providing services to Spanish-speaking clients was central to the participants' development as bilingual clinicians. Similar to the non-Latina/o clinicians in Verdinelli and Biever's 2013 study, participants who often had little to no formal training of working with monolingual and bilingual Spanish-speaking clients, benefited from clinical experiences as in-vivo training.

Cultural competence requires self-reflection. Speaking with participants, it became clear that while programmatic training of cultural competence focused primarily on teaching them about their clients, they often found it important to spend time exploring their own values. Similar to the experiences noted in Verdinelli and Biever's study of cross-ethnic therapy, working with Latina/o clients often revealed the clinicians' own values through contrast with their clients' values. This supports further study of self-exploration as an important dimension of clinical training for cross-ethnic therapists.

Experience Conducting Therapy

A variety of themes arose around the experience of clinicians providing therapy in Spanish including: 1) increased energy and focus required to provide therapy in Spanish; 2) significant anxiety, especially early in career, providing services to Spanish-Speaking clinicians; 3) importance of recognizing influence of the clinician's own belief system, biases, and life experience on their reactions and work with Spanish-speaking clients; 4) more flexible boundaries (similar to Verdinelli and Biever's study of cross-ethnic therapists in 2013) ; 5) therapeutic utility of code-switching; 6) willingness to ask for clarification and/or to acknowledged misunderstanding; 7) different therapeutic stance whether working in English or Spanish. These themes and struggles are similar to those

noted by both non-Latina/o and Latina/o participants in past studies on the experience of bilingual clinicians. (Biever et al, 2002; Castaño et al, 2007; Verdinelli and Biever, 2013).

Plan to manage anxiety. Participants noted that working in Spanish often generates added anxiety regarding linguistic difficulties. Most clinicians discussed asking clients when they are unclear on a word, a greater proportion of clinicians than those in a previous study of clinicians providing mental health services in Spanish (Castaño, 2007). While past study of non-Latina/o clinicians confirmed difficulties with finding words, no mention was made of asking clients when at a loss for words (Verdinelli and Biever, 2013).

It should be noted that two clinicians reported anxiety due to not understanding a client which contributed to anxiety that exacerbated their difficulty focusing. In one case, shame regarding not understanding led a clinician to not request clarification. Other clinicians noted that anxiety had negatively impacted their effectiveness at times. As a result, it is vital that clinicians be prepared to acknowledge and manage their anxiety regarding working in Spanish. Given previously reported sense of isolation by Spanish-speaking clinicians (Verdinelli and Biever, 2009b) learning to manage anxiety is even more important given clinicians are often the only Spanish-speaking clinician at a specific location. Both a past study of Latina/o clinicians (Verdinelli and Biever, 2009b) and participants of the present study noted that clinicians who are not bilingual frequently do not understand the challenges specific to working in Spanish. As a result, speaking with colleagues will most likely increase a clinician's sense of isolation and anxiety rather than resolve it.

Lack of Spanish-language clinical opportunities and colleagues. Structured clinical opportunities to learn from more experienced colleagues while working with majority Spanish-speaking clients are difficult for trainees to find. This difficulty persisted after graduate training as clinicians are often the sole Spanish-speaking clinician at a given setting, often leading to a sense of isolation and a lack of colleagues with whom to reflect on their experience. Isolation due to lacking Spanish-speaking colleagues has been echoed by past studies of clinicians working with Latina/o clients in Spanish (Biever, Castaño, De Las Fuentes, González, Servín-López, Sprowls, and Tripp, 2002).

‘Appropriate’ boundaries are culturally determined. A major aspect of clinicians’ experience working with Spanish-speaking Latina/o clients was the reality of working to bridge the difference between ‘appropriate’ clinical boundaries per their training and working in a culturally aware and attuned manner. Clinicians noted that their Spanish-speaking patients often ask about how they learned Spanish, in addition to being more likely to ask about other aspects of their lives. While most clinicians noted feeling comfortable sharing more with Spanish-speaking clients, colleagues who did not work with Latina/o clients were experienced looking askance at the “loose” boundaries that they perceived. Additionally, clinicians noted occasionally being offered small gifts of baked goods or other items, which would be perceived as offensive to refuse.

Bilingual Clients. As noted by past studies, and also found by this study, working with Spanish-English bilingual clients adds another dimension to the clinical services and the responsibilities of the clinician.

Determining primary language for communication. While a lack of consistent method for determining the language preferred by bilingual clients can be seen in this

study, this suggests that methods to guide a determination would be helpful. Whether taking a psycholinguistic history (Pérez-Foster, 1998) or, for those not from a psychodynamic background, administering Altarriba's bilingual client language proficiency questionnaire (1992 as cited in Santiago-Rivera & Altarriba, 2002) use of a similar measure would be helpful in guiding language choice for both therapy and assessment.

While bilingual clients in therapy may opt to code switch at times or express preference for a specific language, this is less than ideal when engaging in psychological assessment. Given the reported lack of access to measures developed in Spanish, and normed for Spanish-speaking populations, it is possible that bilingual clients who appear proficient in English may be provided English language forms without regard for their relative proficiency. While there are a number of organizations suggesting best practices, it may be important for these practices to be more widely disseminated given the number of Spanish-speaking clinicians who may engage in assessment with varied levels of training. Were the neuropsychological field to establish best practices to determine the best language(s) in which to conduct an evaluation, it would greatly aid the quality of assessments conducted. It should be noted that the measures available to determine varying degrees of Spanish proficiency have not been developed to the same degree as the English language measures.

Working with mixed bilingual families. One theme that arose numerous times was the complex task of working with mixed bilingual families, and the factors that may cause conflict in mixed bilingual families. A common reality noted was a child serving as interpreter for their parents at other agencies, acculturative stressors on the family,

especially when children acculturate to US culture while parents more strongly connect to their mother culture's value. This can lead to conflict between the US ideal of teenagers engaging in separation-individuation and their parents' and extended family's greater focus on family unity and support that is often more prevalent in Latin American countries.

When working with mixed bilingual families, clinicians discussed the importance of developing methods to overcome the language barrier, whether interpreting for parents and children in session and/or focusing work on improving non-verbal communication skills, it was noted to be a central aspect of working with mixed bilingual families. Improving non-verbal skills was identified as one avenue to improve communication and emotional support within a family without requiring family members to improve their linguistic skills.

Language choice for assessment of bilingual clients. As noted by participants, decisions regarding optimum language of assessment varied in the degree of thought involved. Participant reports ranged from a "snap decision" to client's stated and written preference, and at times the referral source (i.e., school referrals administered in English based on language of learning). Most clinicians noted simply going with the language preference stated by paperwork and confirmed by a client. No clinicians displayed knowledge of formal language dominance measures such as the Language Assessment Scale, Oral (LAS-O), the Woodcock-Muñoz Language Survey, or the Language Assessment Scales-Reading and Writing as noted in Cofresi and Gorman's article (2004).

Spanish language assessment materials and training are lower quality. While clinicians with positions specifically focused on psychological evaluation had Spanish

language measures, multiple participants noted, as confirmed by past studies (Fortuny et al, 2005), that psychological measures available in Spanish are not developed to the same standards as English language measures. Furthermore, informal assessment by a clinician may be used at times when they are unaware or unable to access a formal measure to accomplish the task.

Scarcity of Spanish-English bilingual supervisors. Including those who attended formal training, a theme that has been echoed by a past study (Verdinelli and Biever, 2009b) is the lack of supervision by Spanish-speaking supervisors. In Verdinelli and Biever's study (2009) of bilingual supervisees, it was found that having monolingual English-speaking supervisors negatively impacts the quality of supervision. Without a supervisor who speaks Spanish, supervisees report feeling isolated, receiving culturally insensitive advice, and having to interpret their experience in session into English, thereby losing potentially clinically relevant information.

Supervision in Spanish. Those clinicians fortunate enough to receive supervision from bilingual clinicians noted that it significantly improved their confidence and comfort providing services to Spanish-speaking Latina/o clients. Additionally, it should be noted that clinicians noted benefits to receiving supervision from bilingual Latina/o supervisors as well as bilingual non-Latina/o supervisors. Supervision from Latina/o supervisors was noted to aid clinicians with furthering their cultural competency and better understand nuances of interactions that may be difficult to identify as a non-Latina/o clinician. On the other hand, receiving supervision from a fellow Spanish-speaking non-Latina/o clinician was noted to provide clinicians with a place to address

their identity as a bilingual non-Latina/o clinician and explore and discuss the experience of providing cross-ethnic services.

Facing structural obstacles to working with Spanish-speaking clients. While not assessed by prior studies, the degree of institutional support for Spanish-language clinical services is an increasing concern. The majority of participants discussed receiving verbal encouragement to provide services to Spanish-Speaking clients, and little in the way of material or logistic support such as bilingual receptionists, or Spanish-language forms or templates. This often results in uncompensated activities such as translation of forms, interpretation for monolingual English-speaking colleagues, both of which add undue stress to the experience of bilingual clinicians. Additionally, being competent to provide clinical services in Spanish is not equivalent to being competent or trained in accurate translation and interpretation from English-Spanish or vice versa, which may place clinicians in an ethical quandary when faced with sub-par translations of English language forms, or no Spanish-language forms at all. Future research on the importance and impact of institutional support on clinician experience and on quality of service provision to Spanish-speaking clients may aid in more thorough grounding of the structure of future programs and clinics.

Little if any formal assessment of clinician's Spanish prior to hiring. As noted by past studies (Verdinelli and Biever, 2013), clinicians who purport to speak Spanish, often a key factor in hiring, are rarely evaluated to assess their Spanish-language competency prior to being assigned a caseload of Spanish-speaking clients. This suggests that there is insufficient oversight regarding the quality of services offered to Spanish-speaking clients. As many sites hiring a Spanish-speaking clinician may lack Spanish-

speaking staff, assessment of Spanish-speaking proficiency may be difficult if not impossible without some measure or certification available for Spanish-speaking clinicians. Yet as noted in this study, depending on level of proficiency required by organizations, the pool of eligible Spanish-speaking clinicians will likely be further reduced, a difficult trade-off at this intermediate stage of developing clinical resources and infrastructure for Spanish-speaking patients.

Desire for Spanish-speaking colleagues. Similar to a past study (Castaño et al, 2007), the opportunity to speak about their experience was often cited as a reason for participating in the study as well as the desire to meet another non-Latina/o Spanish-speaking colleague. This desire speaks to the isolation that results from the current scarcity of Spanish-speaking colleagues and the lack of opportunities for peer supervision or consultation on clinical issues. The level of interest in an opportunity to discuss their experience and work with other Spanish-speaking colleagues suggests that when possible it would be beneficial for clinics to employ multiple Spanish-speaking clinicians to provide greater support and decrease chances of burnout.

Peer reception. Participants reported overwhelmingly positive reception by Latina/o clinicians. The exception to this is that those clinicians who began working in Spanish later in their lives noted a number of conflicts with Spanish-speaking Latina/o colleagues. While this correlation was not expected, one possible explanation may be that the earlier in one's career a focus on working with Spanish-speaking Latina/o patients is developed, the better for a clinician's ability to do so in a sensitive and competent fashion or perhaps the less likely one is to perceive advice and corrections to be criticism. An alternate possibility may be that by working in Spanish earlier in life, one gains more

exposure and insight into the experience of those outside of their identity group, that aids in later clinical work. It is important to not overstate this apparent correlation, yet its possible implications are interesting nonetheless. The potential impact of receiving training and clinical experience earlier in one's career is novel and should be further explored in future studies. If found to be true in a study of a larger scale, it would suggest that it is important for clinicians to begin their training with a focus on working with Latina/o Spanish-speaking clients, rather than re-specializing later in their career. Additionally, developing greater insight into oneself in the process may serve to benefit the clinician in collegial interpersonal settings.

Limitations of the Present Study

Relative homogeneity of the sample. While the qualitative approach enabled this study to gain detailed knowledge of the participants' experience, eleven participants identified as predominantly European American and the twelfth participant was a White British person. While one participant identified as both Persian and White American, the group was mostly racially homogeneous. The results should be understood as reflecting the experience of a specific group of White clinicians providing therapy to Spanish-speaking Latina/o clients. Given the small size and networked nature of the sample, representativeness of White clinicians should not be assumed. At this time it is unclear if a largely White sample accurately depicts the population of non-Latina/o clinicians working with Spanish-speaking clients. A future survey exploring the diversity of Spanish-speaking clinicians in the United States would be beneficial to provide broader context for the results.

False dichotomy of language and culture. Often, during the course of interviews, it became clear that by focusing on the experience of clinicians providing cross-cultural therapy to Spanish-speaking clients, the study appeared to propose a false dichotomy of culture and language. As a result, participants at times discounted observations they had thought of due to a sense that “that’s not so much language as it is culture.” While this study primarily focused on impact of language, it is possible that the findings were narrowed or biased as a result.

A difficulty inherent in the study design is that the phrasing of many questions pre-supposed language as a defining factor in interactions, despite exploring situations in which intersectional approaches are most appropriate. At times, it appeared that this contributed to an unintentional narrowing of the frame for clinicians to respond. During the course of interviews, it became clear that by focusing on the experience of clinicians providing cross-cultural therapy to Spanish-speaking clients, the study created for many participants a false dichotomy of culture and language. As a result, two thirds of participants (8) discounted observations they thought of due to a sense of the causal factor as “not so much language as it is culture.” While this study primarily focused on impact of language, it is possible that the findings were narrowed or biased as a result.

Overly broad focus. While ostensibly focused on language-related issues and experience of clinicians, the interview protocol explored a wide range of topics. This led to a broad overview of topics that arise in clinicians’ experience with less depth devoted to fully explore any single topic.

Spanish Acquisition Focused Recommendations

Speaking Spanish is the first step. The findings of this study specifically demonstrate that while bilingual clinicians are often only asked or assessed on whether they speak Spanish, it is important that clinicians also develop linguistic proficiency writing and reading Spanish. Additionally, linguistic competency means nothing without cultural competence and culturally sensitive clinical approaches.

Proficiency is a process, not a discrete milestone. Nearly half of participants noted that clinicians must gain a sufficient level of Spanish proficiency to work with Spanish-speaking clients and that once attained, constant effort must be exerted to maintain this level of proficiency. Language learning software alone will not suffice to build the necessary level of proficiency for clinical purposes. Ideally, clinicians develop written proficiency as well, although participants' recommendations largely addressed verbal proficiency.

Learn specialized Spanish terms. "If someone's working in business or mental health, they need to know first of all the language in order to be able to converse with someone and then they need to know the specific language for their specialization" As advised by one third of participants, once a clinician has established a sufficient level of Spanish proficiency, the next step is to learn the language and terminology specific to mental health. Clinical use of Spanish also goes beyond learning terms, and extends to recognizing the therapeutic use and implications of code-switching by bilingual clients.

Cultural Competence Focused Recommendations

A number of participants emphasized the importance of being culturally competent as well as linguistically proficient. Their recommendations emphasized that engaging in cross-cultural work involves “far more than a simple matter of translation.” Participant recommendations focused on knowledge clinicians should gain regarding clients and knowledge that should be sought regarding themselves.

One third of participants emphasized awareness of the diversity of Latin American clients and cultures as key to culturally competent work. Some participants also proposed clinicians be trained and “sensitized” to issues of culture including religious perspectives and views of mental health in non-US cultures. Furthermore, it was noted that this is a continual process, one aided by remaining up-to-date on relevant literature. As discussed by Guarnaccia and Rodriguez (1996) “cultures vary not only by national, regional, or ethnic background, but by age, gender, and social class. Much of culture is embedded in and communicated by language; language cannot be understood or used outside of its cultural context.” As such, it is vital that all Spanish-speaking clinicians examine and expand their definition of culture to provide services that are genuinely culturally competent and responsive.

Culture includes socioeconomic and immigration status. Awareness of the importance of both socioeconomic status of clinician, clients, and others in society, was emphasized as vital for clinicians. An understanding of socioeconomic status was tied to broader awareness of a clinician and client’s positions within the social power structures of society. Diversity courses with a focus on guiding clinicians toward greater reflection on their identity in the therapy room and their own experience of cross-cultural work

were recommended to address the need for awareness. Recognition of the marginalization of immigrants in this country was also identified as vital for competent service provision.

Cultivate openness to cultural values. Beyond possessing knowledge, participants emphasized the importance of developing genuine openness in the therapy room. Engagement and acceptance of cultural values and experiences clinicians encounter are as valuable as any knowledge gained from a book. Nearly half of participants recommended experiences, personal and professional, interacting with people from different cultures.

Self awareness of cultural values, biases, and beliefs. Discussing Latina/o Spanish-speaking clients with participants emphasized that self-awareness is a key component to competent practice. In order to provide culturally competent and sensitive services, clinicians must understand and acknowledge their own cultural background and the inevitable impact on work with clients.

Implications for Training Programs

Participants recommended a range of activities and topics for training ranging from culturally-focused to linguistically-focused, and most interestingly empathically focused.

Language learning resources. One quarter of participants advised programs ensure availability of opportunities for students to improve their Spanish-language proficiency through offering of language classes, language-learning software such as Rosetta Stone, and clinical opportunities. For programs training culturally competent and aware professionals, it is important to acknowledge the centrality of students having access to opportunities to learn languages. Given the significant increase in the Spanish-

speaking population in this country, it is vital that programs provide clinicians with opportunities to study and/or improve their Spanish language skills in a variety of manners. (i.e., language-learning software, language classes, immersion experiences). One participant emphasized the importance of continuous opportunities to maintain and improve one's Spanish to develop sufficient proficiency. In summation, access to language learning opportunities is not peripheral.

Another participant who recommended clinicians be offered resources to develop their Spanish-language fluency while in training anticipated one difficulty with the process of integrating language learning and clinical training. She noted that the precise timeframe of learning Spanish and learning clinical information in Spanish involves a delicate juggling of knowledge:

If more of my training had been in Spanish that would help with me acquiring more fluency. But at the same time, if my fluency hadn't been strong enough at the beginning of my program in my training I wouldn't have been able to understand the material in basic therapy in order to even get that foundation, so there has to be a mix of both I think, for a person to gain the therapy skills but also be developing fluency as they go through."

Spanish-language coursework on a range of topics. Participants recommended that programs offer trainees courses on working with Latina/os from theoretical, practical, and historical perspectives. The benefit of coursework in Spanish on both psychopathology and Latin American history was identified as vital to learning both clinical knowledge and comfort with clinical use of language.

Formal training to conduct assessments. Training focused on conducting assessments in Spanish was recommended to aid in “learning the specific vocabulary of the assessments and practicing the assessments in Spanish.” One of two participants who received formal training conducting assessments in Spanish noted that it almost did not occur. “They didn’t have any bilingual interns...and I was invited to sit in on their assessment seminar.... And she [the director] was saying “there’s the case of this nine-year-old boy, but we don’t have anyone to test him.... And I remember sticking my finger in the air [and saying], ‘actually I speak Spanish and I could.’ So she actually took me on to teach me assessments. It wasn’t even in the plans.” Another participant at a post-doctoral position noted that she received advice and guidance on administering psychological testing in Spanish, which served to refresh her skills but was not in-depth training on the topic.

Two participants without specific training in assessment acknowledged they lacked consistent and clear reasoning for their clinical decisions when conducting assessments. One participant observed “there’s...a lot of like flying by the seat of one’s pants with this, you know. In a way which I don’t think one would get away with in other areas of, clinical practice... In terms of the lack of kind of formalized training but also the lack of assessment of like when one language is indicated versus another.” Clearly specific coursework and supervision regarding assessment of Spanish-speakers is necessary for trainees to provide competent, ethical, and valid testing of Spanish-speaking clients.

Training and support groups for self-reflection. Multiple participants reflected on the benefit of exploring issues of their own identity while lacking any structured

environment in which to do so. In addition to training on the culture and identity of Latina/o clients, trainees would benefit from receiving formal training and guidance in exploring their own identities. This may be best accomplished through a combination of formal coursework and peer-support groups with trainees of similar cultural backgrounds.

Exercises to develop empathy for clients. Exercises designed to develop empathy and insight into obstacles faced by Spanish-speaking clients navigating English-speaking systems were recommended by two participants as vital to develop greater insight into clients' experiences.

They picked a different language that nobody understood and they essentially pretended as if we were patients and we were getting diagnostic feedback in a language that wasn't our own. And one of the staff pretended they were the interpreter and another staff pretended they were the doctor speaking the language that wasn't our own. And it was actually kind of jarring to hear them go back and forth and talk, you know, in their own language and you couldn't understand what they were saying. And then they were giving us feedback and really sort of giving us a shock to what is it like. Because... it's sometimes very difficult for us to put ourselves in our patients' shoes and really understand what it feels like to be in a system with which you're not necessarily comfortable.

This recommendation can be understood as representative of the necessity for clinicians engaged in cross-cultural work to engage in learning not only through their use of intellect but also through their use of their emotions, empathy, and broader consciousness of the world within in which both they and their clients live.

Clinical opportunities in Spanish. Three participants emphasized the importance of having numerous clinical placements available to students that provide Spanish-speaking clinical experience. One of these participants emphasized that an ideal clinical setting would have both a majority of Spanish-speaking patients and associated didactics on providing therapy in Spanish. One participant specifically emphasized that it is important for trainees to work with Spanish-speaking clients from a range of regions, countries, and populations to develop an understanding and appreciation for the breadth of experience of Spanish-speaking clients.

Supervisory recommendations. More than half (7) of participants emphasized the importance of receiving supervision by Spanish-speaking clinicians. One quarter (3) of participants explicitly recommended supervision of Spanish-speaking cases be conducted in Spanish. Based on participant experience and recommendation, it would be ideal to receive supervision from bilingual Latina/o clinicians as well as bilingual non-Latina/o clinicians to gain the most insight into one's own culture and views as well as that of one's clients. Observing sessions conducted in Spanish and writing process notes in Spanish were also advised to help build clinical competency in Spanish.

Locate competent Spanish-speaking supervisors. Given the importance of supervision and training in providing clinical services in Spanish, it is important that training programs assist students with locating and cultivating supervisory relationships with competent Spanish-speaking clinicians. While training programs often have supervisors within their program, or closely tied to the program, the task of finding Spanish-speaking supervisors for Spanish-speaking clients often falls to trainees, creating an undue burden on trainees seeking to provide culturally and linguistically responsive

services.

Supervision from Latina/o and non-Latina/o bilingual clinicians. Developing awareness of their own identity development while providing therapy to Spanish-speaking clients may be best supported by receiving supervision in Spanish from a combination of bilingual Latina/o and non-Latina/o clinicians. Latina/o bilingual supervisors provide trainees with important guidance and education on cultural topics and potential insight into some aspects of client-side of the therapeutic relationship. At the same time, significant benefits are to be gained from culturally competent non-Latina/o clinicians in the area of trainee identity development. This provides clinicians with the opportunity to explore with greater depth the experience of both their clients and themselves with perhaps greater comfort to explore their own biases and cross-cultural experiences.

Implications for non-Latina/o Clinicians

Working in Spanish requires more energy. When starting out, it may be advisable to carry slightly lower caseload than what you feel is possible working in English. Given the higher level of energy and care required when working in your second language, it is important to make accommodations, whether that is scheduling Spanish-speaking cases earlier in the day, or scheduling fewer in a single day, as well as being certain to consult other Spanish-speaking clinicians when high risk cases present themselves later in the day.

You are not alone. Both for simple awareness, and to encourage clinicians to seek out and connect with others, it is important that non-Latina/o clinicians conducting cross-cultural therapy in Spanish be informed that they are not alone in this effort. Others

are likely having similar experiences to them, and if they reach out, they may receive validation, encouragement, and helpful advice for their clinical work.

Connect with other Spanish-speaking clinicians. Interaction with other Spanish-speaking clinicians is important to professional development, whether in the form of group supervision or mentors. Two participants found working with a non-Latina/o bilingual mentor to be highly beneficial for developing clinical skill and self-awareness.

Implications for the field

Spanish-speaking clinicians are islands in need of bridges. Given the apparent reality of so few Spanish-speaking clinicians in the field, most Spanish-speaking clinicians end up as the sole Spanish-speaking clinician at their location. This leads Spanish-speaking clinicians to feel isolated and without others to discuss their experience or consult. It is strongly advised that a support network be developed for Spanish-speaking clinicians. While the ideal would be supervisory groups that take place in person, the establishment of a professional network or even an online supervisory group would also provide much needed connection. For clinicians working in Spanish, such a group would help to reduce the sense of isolation and lack of ability to request clinical consultation that bilingual clinicians have noted.

Supervisory groups specific to White American clinicians working with Spanish-speaking Latina/o clients would benefit those clinicians by providing a ‘safe’ space to explore their own identities as White clinicians. As a number of participants were unaware that other White clinicians were engaged in similar work, a supervisory group specific to non-Latina/o clinicians working in Spanish would also be beneficial. The key

is that these groups be supervised by clinicians with sufficient experience and grounding in the best practices. Additionally, it is important that such groups serve as places for clinicians to explore their own biases.

Implications for clinics that work with Spanish-speaking clients

In order to support both clinicians and Spanish-speaking clients, it is vital that clinics increase accessibility of mental health services. Increasing access to mental health services will require modifications to both hiring practices and materials available in clinics.

Increase hiring of Spanish-speaking clinicians and support staff. In order to provide adequate and ethical care to Spanish-speaking clients it is important for clinics to employ both Spanish-speaking clinicians and Spanish-speaking administrative staff. Hiring more Spanish-speaking clinicians is essential to meet current and growing demand, yet it is also important to recognize that employing Spanish-speaking clinicians is the beginning not the end of developing a culturally competent clinic. Hiring Spanish-speaking clinicians is only one side of the equation. It is also important that the clinic's contact person, and face to the waiting room does not create additional obstacles to service-utilization by requiring Spanish-speaking clients to navigate English-language staff interactions.

Hiring support staff serves multiple purposes, all of which are vital to increase the quality of services. Providing clients with a setting within which they may communicate with all providers present may increase their comfort and willingness to engage in services. At the same time, by having Spanish-speaking, and ideally writing, support staff, clinicians will be able to devote more time and effort to their core clinical tasks and

not be burdened by important yet peripheral tasks such as translating documents, fielding all Spanish-language calls, and possibly even interpreting.

Employ a minimum of two Spanish-speaking clinicians in your clinic. Another participant noted that organizations that employ more than one Spanish-speaking clinician, provide greater opportunities for peer support and supervision of Spanish-speaking clinicians. This is a tall order given the scarcity of Spanish-speaking clinicians. Having two Spanish-speaking clinicians provides greater support to the clinicians through peer supervision and consultation, as well as a higher level of care to clients. Without an additional Spanish-speaking colleague, Spanish-speaking clinicians may find themselves lacking resources for consultation and at increased risk for burnout.

Formally assess and acknowledge clinician Spanish language proficiency.

Another clinician noted that clinics may provide a greater sense of institutional support to clinicians by formally assessing and recognizing clinicians' Spanish language ability. Once clinicians have been determined to speak Spanish at a level adequate to provide clinical services in Spanish, it may be noted on clinician badges. Beyond the benefits to clinicians, such assessment will directly benefit the clients that are served. It is important that clinics balance the need for Spanish-speaking clinicians with ensuring that clinicians possess adequate Spanish proficiency to provide competent care to Spanish-speaking clients. One participant recalled obtaining her first job out of social work school with a low level of proficiency. She stated she was given the job "because I spoke Spanish.... I found they didn't care if I was fluent, just speaking a little Spanish I got a good job." While the drive to hire more Spanish-speaking clinicians is vital, if clinics do not ensure proper evaluation of clinicians, both Latina/o and non-Latina/o, who purport to "speak

Spanish,” any added effort and resources directed toward Spanish-speaking clients would both be ineffective, and contribute to supporting incompetent and borderline unethical treatment of clients.

Clinicians are not translators. In the same way that clinicians have received significant training to provide mental health services requiring certification, the same is true of interpreters and translators. To place clinicians in the role of interpreter or translator is to not only take away from their focus on providing clinical services, but to place them in a questionably ethical role of serving in a role for which they have not been trained.

Spanish language documentation is not optional. It is important that Spanish language materials not require on-the-fly translation or interpretation by bilingual clinicians. This inevitably impacts the quality and level of thought put into such materials. In addition, the lack of documentation for clients conveys a lack of forethought on the part of the clinic, contributing to the broader societal marginalization of Spanish-speaking clients.

Systems-Focused Recommendations

Nearly half of participants provided recommendations regarding the broader systems that impact Spanish-speaking clients and clinicians. These recommendations focused on three areas: recruitment of Spanish-speaking clinicians, greater support of Spanish-speaking clinicians in the field, and the establishment of a minimum required level of Spanish proficiency.

Available resources and programs must be publicized. While it is great that training programs are being established with focus on Latina/o mental health (Pacific

University-Oregon, Our Lady of the Lake University, Massachusetts School of Professional Psychology) in order for applicants to apply, they must first know the programs exist.

Clearinghouse of Spanish-language material. As noted by participants, despite increasing numbers of Spanish-speaking clients, most clinics lack forms in Spanish. As a result, participants reported being placed in the position of interpreting forms on the fly when asking clients to consent to treatment or release of information, or given the added task of translating clinical forms, despite lacking training to do so accurately. An online repository of professionally translated Spanish language clinical forms would both help to raise the standard of materials offered to Spanish-speaking clients, and to reduce the added burden placed on Spanish-speaking clinicians.

Increased recruitment of bilingual and bicultural clinicians needed. Not only would clients benefit from a greater pool of bilingual and bicultural clinicians, so too would the professional field. The current lack of supervisors who are bilingual and culturally competent contributes to a bottleneck of both supervisory experiences and as a result, training opportunities, for clinicians seeking to work with Spanish-speaking clients. This is a complex process as noted by Peters, Sawyer, Guzmán and Graziani (2014), which also requires that any Latina/o clinicians recruited not be pigeonholed into working only with Spanish-speaking clients unless that is their interest.

Increase recruitment of bilingual-bicultural applicants to doctoral programs. A drive to increase recruitment and encouragement of bilingual, and bicultural applicants starting in college, possibly even high school was regarded as vital by some participants. It is important to note that a clinician noted that more native Spanish-speaking clinicians

would be a great benefit, but that it is not enough to be a native Spanish-speaker, one should ideally also be educated in Spanish.

Establish a minimum level of Spanish language proficiency. Currently, clinicians often self-determine if they possess sufficient proficiency in Spanish to conduct therapy. The establishment of a minimum standard for Spanish proficiency would have the benefit of validating the importance of sufficient Spanish proficiency to provide clinical services. Additionally, it may serve to validate the idea that when providing services in Spanish, linguistic proficiency is an inherent aspect of clinical competency.

Implications for Future Research

Research racial identity development of clinicians conducting cross-cultural therapy. While central to provision of culturally competent cross-cultural therapy, this study found that a majority of the clinicians experienced discomfort exploring topics related to racial identity, a significant issue in cross-cultural therapy. Future research focused on the development and impact of cross-cultural clinicians' racial identity development may clarify other variables that impact both client and clinician experience of cross-cultural therapy.

Explore the experience of Spanish-speaking clients receiving cross-cultural treatment. Along a similar line, while not the focus of this study, future research on clients' experience of cross-cultural therapy will provide important feedback on the current state of cross-cultural therapy. It is well known that Spanish-speaking clients face a variety of obstacles in receiving treatment, but little is known about their experience receiving cross-cultural therapy.

Design methods to increase connection among Spanish-speaking clinicians.

This study found a sense of isolation and lack of opportunities to consult with other Spanish-speaking clinicians to be common among the participants. Given the importance of reducing Spanish-speaking clinicians sense of isolation in their work, it would be highly beneficial to explore various methods of reducing the isolation. This may include studies of possible peer-supervisory groups as established by training programs, clinics, or outside professional organizations.

Explore Implicit Meanings of “Spanish-speaking clients.” Throughout this study, clinicians were found to use the straightforward yet vague term ‘Spanish-speaking clients.’ Use of this term included various unexplored underlying assumptions, values and biases, both positive and negative. Future research guiding non-Latina/o clinicians in exploring their explicit and implicit associations regarding English and Spanish-speaking Latina/o clients would be invaluable information to improve training.

Conclusion

This study was developed with the goal of exploring the experience of non-Latina/o mental health clinicians providing services to Spanish-speaking Latina/o clients toward the objective of identifying valuable skills and knowledge needed to develop competency to work with Spanish-speaking clients. Participants’ experiences reflected previous studies of experience of Latina/o clinicians working with Spanish-speaking clients in some ways, and departed from the literature in other ways.

While bilingual English and Spanish-speaking clinicians are currently a small minority in the field of mental health, this is one of the few studies that specifically explored the experience of non-Latina/o bilingual clinicians. Similar to literature

regarding work with Spanish-speaking clients, cultural and linguistic knowledge were found to be necessary for competent practice as a bilingual clinician.

Participants' experiences revealed that Spanish proficiency is a continual process rather than a discrete achievement, often beginning in secondary school, and continuing throughout their careers. Learning Spanish process often involved consumption of Spanish-language media, socializing with Spanish-speaking friends and co-workers, and immersion experiences.

The importance of awareness and knowledge of their clients' cultural values, beliefs, and biases related to ethnicity, religion and socioeconomic status was noted to be vital. Participants repeatedly discussed the importance of self-awareness of how their own beliefs and experiences may differ from their clients. In addition to learning about the diversity of Latina/o clients and their backgrounds, participants discussed the importance of learning to communicate clinical concepts in Spanish, a topic lacking amongst those trained in English. The majority of participants received little if any formal training to provide such services. As reported by past studies, there continues to be a significant lack of supervisory and training opportunities for trainees seeking to provide services in Spanish.

Novel findings include increased levels of energy and focus required to work in Spanish, a lack of institutional support for Spanish-speaking clinicians, benefits of receiving supervision from non-Latina/o and Latina/o clinicians and a lack of awareness of existing resources for Spanish-speaking clinicians. While clinics have begun to increase hiring of Spanish-speaking clinicians, the majority of support afforded bilingual Spanish-English clinicians appears to be in the form of verbal encouragement. As a

result, Spanish-speaking clinicians are frequently without Spanish-language forms or assessment measures. Once in the field, Spanish-speaking clinicians tend to lack colleagues with whom they may consult regarding issues of language and culture, due in part to the scarcity of Spanish-speaking clinicians.

In order to increase the pool of linguistically and culturally competent Spanish-speaking clinicians, it is vital that more supervisory and clinical opportunities be developed. Broader dissemination of training resources, best practices, and guidelines for assessing and treating Spanish-speaking clients would likely help to increase the awareness and competence of Spanish-speaking clinicians.

Participants' recommendation regarding necessary skills for competency centered on four factors: proficiency in Spanish, knowledge of clinical and cultural concepts regarding Spanish-speakers, knowledge of oneself and an openness to asking "what does that mean?" Most critically, participants recommended a need for increased support in training programs, and increased support in mental health settings for Spanish-speaking clinicians and clients. Establishing greater connection and support amongst Spanish-speaking clinicians would help to reduce the anxiety and burden noted by participants.

Based on participant recommendations, the field of Spanish-speaking clinicians may benefit from the creation a professional network for Spanish-English bilingual clinicians. This network would ideally include an identity-based special interest group for clinicians of non-Latina/o backgrounds to explore the experiences unique to cross-cultural and cross-ethnic service provision in Spanish. Finally, a clearinghouse of accurately translated Spanish-language clinic documentation would improve the quality

and availability of forms for clinics and reduce the burden often placed on bilingual clinicians serving as unofficial translators and interpreters of English language forms.

As this study is one of the few studies of the experience of non-Latina/o clinicians working in Spanish, further research into the findings is warranted. Future research designing a training program based on the results would be helpful in translating the findings to concrete changes for programs and clinics to implement. Exploring the relevance of the results in a larger pool of bilingual clinicians would be useful in further broadening the utility of any training programs based on the results. Overall the study supports the need for increased training and support of Spanish-speaking clinicians, and suggests that the scarcity of Spanish-speaking clinicians contributes to increased isolation and burdens on clinicians. This study supports greater exploration and development of training designed for all potential bilingual clinicians to better meet the needs of the growing Latina/o population of the US and the clinicians that serve them.

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APPENDIX A

Codebook

Code	Definition	Parent Node
Socializing in Spanish	mention of socializing in Spanish as key aspect of practicing Spanish	Competency Development
Professional Spanish	Addressing development and use of clinically-oriented Spanish	Competency Development
Professional Preparation	Regarding how clinician gained clinical and professional Spanish proficiency	Competency Development
Practicing Spanish Continually	discussion of continuously practicing Spanish	Competency Development
Learning Spanish Setting	Mentions of different settings (secondary school, language school, immersion, informal) that participant learned Spanish	Competency Development
Learning Spanish	Regarding motivation and process by which clinician learned Spanish	Competency Development
Language of Training Impact	regarding clinician experience of training in language other than the language of their clients	Competency Development
Gaining Clinical Experience in Spanish	Discussing setting and experience of beginning to work in Spanish	Competency Development
Formal Training	Responses to prompt about formal training received to conduct therapy in Spanish	Competency Development

Enjoying Audiovisual Media in Spanish	discussion of consuming audiovisual media in Spanish	Competency Development
Competency- Self Perception	How competent do you feel in providing Spanish language services?	Competency Development
Competency Development	Question regarding how clinician developed their skill working with Spanish-speaking clients	Competency development - TOP LEVEL
Conflict with Training	Prompt regarding clinician experience of conflict between personal belief of best action given cultural values and action dictated by training	Conflict with training - TOP LEVEL
English treatment Vs. Spanish treatment	Comparing and Contrasting Working wit ES clients vs. SS clients	English treatment Vs. Spanish treatment - TOP LEVEL
Experience Conducting Assessments in Spanish	Discussion of conducting assessments of monolingual and bilingual Spanish-speaking clients	Experience Conducting Assessments in Spanish - TOP LEVEL
Assessing client comfort	clinicians' method for determining client comfort in English/Spanish	Experience Conducting Therapy
Working with Split Bilingual Families	Discussion of working with families where parents speak primarily Spanish and children speak primarily English	Experience Conducting Therapy in Spanish
Working with Multiple Languages in Family Sessions	experience of family sessions with mixed bilingual families	Experience Conducting Therapy in Spanish
Language of Thinking in Session	language of clinician's internal monologue in session	Experience Conducting Therapy in Spanish
English treatment Vs. Spanish treatment	Comparisons and Contrasts of Working with ES vs. SS	Experience Conducting Therapy in Spanish
Conflict with Training	experiencing conflict between clinician's clinical judgment and that recommended by training	Experience Conducting Therapy in Spanish

Conflict with North American Concepts	Regarding conflict with north American conceptualization of mental health/illness when working with Spanish-speaking patients	Experience Conducting Therapy in Spanish
Bilingual Client	Discussion of work with Spanish-English bilingual clients	Experience Conducting Therapy in Spanish
Impact of Identity	questions regarding impact of gender, sexuality, race, religion, etc. on experience	Impact of Identity - TOP LEVEL
Language of Thinking in Session	discussion of language of a clinician's internal monologue	Language of Thinking in Session - TOP LEVEL
Linguistic Impact on Service Provision	ways that clinician's and client's language competency and use impact services	Linguistic Impact on Service Provision - TOP LEVEL
Receiving Supervision of Spanish-Speaking Cases	Experiences receiving supervision of SS cases	Receiving Supervision of Spanish-Speaking Cases - TOP LEVEL
Scarcity	References to lack of resources, opportunities, etc.	Scarcity - TOP LEVEL
Referrals	experience receiving referrals of Spanish-speaking clients	Systems and Organizational Issues
Peer Reception	experience of reception by peers	Systems and Organizational Issues
Institutional Support	experience of support at the institutional level	Systems and Organizational Issues
Systems and Organizational Issues	Discussion Related to the systems within which clinicians work	Systems and Organizational Issues - TOP LEVEL
Experience Conducting Therapy in Spanish	thoughts related to conducting therapy in Spanish	Systems and Organizational Issues- TOP LEVEL
Watching Videotapes of Sessions	Training Recommendations	Training Recommendations
Unaware of Training Resources	Lacking awareness of training opportunities	Training Recommendations

Training Programs	Recommendations regarding training programs	Training Recommendations
Systems Level Recommendations	Recommendations directed at the mental health system	Training Recommendations
Supervision specific	Recommendations regarding supervision	Training Recommendations
Immersion Experience	Recommendation of immersion experiences	Training Recommendations
Engaging with Colleagues on Issues	Recommendation of consulting and discussing clinical and cultural issues with colleagues	Training Recommendations
Engage with Professional Organizations	Recommendation of joining groups such as NLPA, HNS, etc.	Training Recommendations
Training Recommendations	clinician recommendations for improvement of training for bilingual clinicians	Training recommendations - TOP LEVEL

APPENDIX B

Interview Protocol**Spanish Language Learning History**

In what setting(s) did you learn Spanish?

Path to being bilingual mental health professional

How have you developed your competency in working with Spanish-speaking clients?

Please describe what informal methods you have used to prepare yourself for using Spanish in your professional work.

Experience Conducting Therapy in Spanish

Now, in answering these questions, I'd like you to think about your clients who are primarily Spanish-speaking.

How recently have you worked with a client in Spanish?

How often do you work with Spanish-speaking clients?

What % of your caseload is Spanish-speaking clients?

What therapeutic modalities (family, couples, individual) have you used in Spanish?

How competent do you feel in providing Spanish language services?

What issues have you worked with in Spanish?

Experience Conducting Therapy

Tell me about your experience conducting therapy with Spanish-speaking clients

Compare and contrast your experience of conducting therapy in Spanish and in English
Aspects that are more difficult/different in Spanish vs. English?

Tell me about your approach to conducting therapy in Spanish

How does that compare with your approach to conducting therapy in English?

How does conducting therapy in Spanish affect your experience during session?

Follow up:

- Difference in emotional experience in Spanish?

- Difficulty with vocabulary?
- Ever found yourself at a loss for words when working in Spanish?
 - How did you manage the situation?

Have you had difficulties with either yourself or your client misunderstanding an interaction?

What factors do you believe contributed to the misunderstanding?

Do you work with bilingual clients? If so, continue.

What is your experience of using more than one language in session?

How do you feel speaking multiple languages impacts the therapy session?

How do you assess a client's relative level of comfort communicating in English and Spanish?

If a client is bilingual, how do you determine what language to conduct therapy in?

Language Choice

What is your experience of bilingual clients' choosing to speak in English or Spanish?

Could you give me an example?

What do you think your clients' may be experiencing when they choose what language to speak?

What is it like for you when you switch from Spanish to English?

Could you give me an example?

What's it like for you to switch from English to Spanish or vice versa?

What do you think it's like for your client when you switch languages?

What kinds of things do you imagine may be going on with your clients when that occurs?

What role, if any, does language choice play in your therapeutic interventions with clients?

What's it like when the person uses a word or phrase that you don't recognize?

Could you give me an example?

What is it like when a person uses a word you thought you knew but it doesn't have quite the same meaning that you recognize?

How do you respond if you use a phrase or word that your client doesn't recognize?

Impact of Identity on Therapy in Spanish

What impact do you feel cultural identity has on your work with Spanish-speaking clients?

(Therapist AND Client)

Race/ethnicity?

Gender?

Sexuality?

Religion?

Could you give me an example?

What is your understanding of your client's experience of your cultural identity?

What cultural values or concepts have you found salient when working with Spanish-speaking clients?

Conflict between Clinical Knowledge and Cultural Knowledge

If there is a conflict between what you personally feel is best for your client and the course prescribed by your training, how do you respond?

What is it like when a client discusses mental health/illness in a way that doesn't fit North American concepts of mental health?

Example?

Systems Experience

What type of institutional support do you receive to provide therapy in Spanish?

What is your experience of receiving referrals of Spanish-speaking clients?

What is your reception by peers as a non-Latina/o bilingual professional?

Training Experience and Recommendation

Experience

What, if any, formal training did you receive in conducting therapy in Spanish?

How has your training served you in your work?

What do you find most helpful from your training?

What training experiences would you like to have received?

Recommendations

What types of experiences would you recommend/not recommend for clinicians currently in training to conduct therapy in Spanish?

What kinds of training do you feel you need to be an effective bilingual therapist?

What do you feel is the impact of the language of your mental health training on your work in Spanish?

What other suggestions do you have to improve the training of students desiring to provide competent psychological services in a language other than English?

Experience as a Bilingual Professional

Do you feel there is a difference in the level of competency you feel versus the level of competency perceived by your clients? By colleagues?

Could you give me an example?

Have you ever referred a Spanish-speaking client to a Latina/o clinician rather than see them yourself?

a. If so, why?

APPENDIX C

Demographic Questionnaire

Modified and Adapted from Questionnaire by Castaño, M. T., Biever, J. L., González, C. G., & Anderson, K. B. (2007)

Age _____ Gender _____ Sexuality _____

Ethnicity _____ Race _____

Training information

Highest professional degree _____ Date of highest degree _____

If you are currently enrolled in a doctoral program in psychology:

Year you began your doctoral program: _____

How many semesters of practica have you completed? _____

Did you receive your professional training in English? Y N

If no, what language were you trained in?

1. What language(s) other than English do you use most often in your practice?
2. How would you rate your level of fluency in Spanish?
1 = Novice 2 = Intermediate 3 = Advanced 4 = Fluent 5 = Native-equivalent
3. Please write the number that best describes your skills in Spanish (using the scale above):
Conversational Proficiency: _____
Reading Proficiency: _____
Writing Proficiency: _____
4. How did you learn Spanish? (Check all that apply)
_____ As first language in home. At what age did you begin speaking English?
_____ Concurrent with English.
_____ Attended school in a non-English speaking country. Which grades?
_____ Elementary/Middle School/Junior High classes. How many years?
_____ High School classes. How many years?
_____ College classes. How many semesters?
_____ Other language classes (e.g. immersion experience). Please describe:

5. For what length of time have you:

Studied Spanish in an academic setting? _____

Lived in a predominantly Spanish-speaking community? _____

Studied/Worked in a Spanish-speaking country? _____

6. What formal training experiences have you received in conducting psychotherapy and/or psychological assessments in a language other than English? (Check all that apply)

_____ All of my graduate education was in a language other than English

- ☐ One or more courses in therapy and/or assessment in a language other than English
☐ One or more courses in professional/technical use of a language other than English
☐ Supervised practica or internship with clients who spoke a language other than English
☐ Postgraduate supervision in using a language other than English for therapy and/or assessment
☐ Postgraduate courses or workshops
☐ Other (please specify):
☐ No formal training in using a language other than English in professional settings
7. To what degree are you concerned about using the following appropriately when providing psychological services in Spanish? Circle a number according to the following scale:
 1= not concerned 2= slightly concerned 3= moderately concerned 4= very concerned
- | | | | | |
|---|---|---|---|---|
| ▪ Vocabulary | 1 | 2 | 3 | 4 |
| ▪ Grammar/Spelling | 1 | 2 | 3 | 4 |
| ▪ Conversational fluency | 1 | 2 | 3 | 4 |
| ▪ Application of concepts, theories and interventions (transition of skills from English to other language) | 1 | 2 | 3 | 4 |
| ▪ Other: _____ | 1 | 2 | 3 | 4 |
8. Please rate the importance of each of the following training experiences for bilingual professional competency using the following scale: 1= not useful 2= somewhat useful 3= useful 4= very useful
- ☐ Supervision in the language in which therapy and assessments are conducted
☐ Availability of professional books or journals in the language in which therapy and assessments are conducted
☐ Course(s) in the technical or professional use of the language in which therapy and assessments are conducted
☐ Course(s) in the culture(s)
☐ Course(s) in the effects of language and cultural variables in assessments and psychotherapy
☐ Course(s) in methods or techniques for bilingual assessment
☐ Course(s) in methods or techniques for bilingual psychotherapy
9. Which of the following services do you provide in a language other than English?
- ☐ Individual therapy
☐ Couple or family therapy

- _____ Group therapy
- _____ Psychological assessment
- _____ Psychoeducational assessment
- _____ Supervision
- _____ Consultation
- _____ Training, teaching, or other educational service

What percentage of your time is devoted to providing these services? _____ %

How many years have you been providing these services? _____

10. Please list current resources, including books, journals, and other training materials which you have found useful in providing services in Spanish
11. Please rate the current need for bilingual therapists and/or psychologists on a 4-point scale with 1 representing low need for well-trained, competent providers and 4 representing a critical need for well-trained, competent providers in languages other than English.

APPENDIX D

Informed Consent Form

1

ATTACHMENT 4: INFORMED CONSENT FORM

Informed Consent Agreement

Study Title: The Experience of Non-Latino Clinicians Providing Bilingual Psychotherapy (Spanish-English)

Invitation to Participate: You are invited to participate in a research study that is being conducted by Daniel Braman, Psy.M, an advanced doctoral candidate in the Clinical Psychology Psy.D. program at the Graduate School of Applied and Professional Psychology (GSAPP) at Rutgers University. Before you agree to participate in this study, you should know enough about it to make an informed decision.

Purpose: This study explores the perceptions and concerns of non-Latino therapists conducting therapy with Spanish-speaking clients as well as their perceptions and concerns regarding their own competence in conducting therapy in Spanish. Research literature on conducting therapy in Spanish has focused primarily on Latino therapists to date. However, a more in-depth understanding of conducting Spanish-English bilingual therapy requires widening the focus to non-Latino Spanish-English bilingual clinicians as well. Given the disparity in mental health services and Latinos in the US, producing more well-trained clinicians for Latinos will require a focus on the training and experience of non-Latino bilingual psychotherapists for future training programs.

Participants: This study will use a network sample of approximately 20-25 non-Latino mental health practitioners working with Spanish-speaking clients.

Procedure: If you participate in the study, you will be interviewed individually during a designated time at an agreed upon location. It is expected that the interview will take 60-90 minutes to complete. However, the length may vary depending on the depth of the answers provided. All interviews will take place in-person at a location in New York, New Jersey or Pennsylvania or via video conferencing, mutually agreed upon by you and Daniel Braman via phone or Skype. All in-person interviews may be conducted in your home or office or in a secure room at Rutgers University to ensure a private, comfortable setting that is convenient for the interviewees. For those interviews taking place via video conferencing, it is important to choose a place to talk that is comfortable and private. In case of video conferencing, the interviewer will be alone, at home or in a secure room in the Psychology Building at Rutgers University.

Risk/Benefit: There are no known risks associated with your consent and participation in this research study. Participation in this study may not benefit you directly; however you will play a major role in helping other researchers, social workers, psychologists, and others understand the experiences of non-Latino clinicians conducting Spanish-English bilingual therapy.

Compensation: There will be no compensation for your participation in this research study.

APPROVED

Subject's Initials _____

JUN 19 2013

Approved by the
Rutgers IRB

Cost: There will be no cost to you for participating in this research study.

Confidentiality: This research is confidential. The research records will include some information about you and this information will be stored in such a manner that some linkage between your identity and the response in the research exists. Some of the information collected about you includes: your name, age, ethnicity, education history, and employer. You will not be asked to disclose any confidential information about clients. Please refrain from providing identifying information. Any information that you provide which may be used to identify clients will be removed from the transcript. Names of people and places will be replaced with pseudonyms. Please note that I will keep information confidential by limiting individual's access to the research data and keeping it in a secure location in the researcher's residence.

Data: Hard copies of interview data and audio recordings will be stored in a locked filing cabinet and no one other than the researcher will have access to this information. Both audio recordings and the transcriptions will be stored on a password-protected computer at the principal investigator's residence and encrypted using the AES-256 encryption standard. In addition, you will be given an identification code and a pseudonym and only the researcher will have access to the code key. The research team and the Institutional Review Board at Rutgers University are the only parties that will be allowed to see the data, except as may be required by law. If a report of this study is published, or the results are presented at a professional conference, your information will be disguised to not have any identifiable information. All study data will be kept for at least three years after completion of the research, all documents with identifying information will be shredded, any audio files or other computer files will be erased by the researcher at this time.

Risks/ Benefits: The interview focuses on your experiences of working with Spanish-speaking clients and your Spanish-language training recommendations. It is the principle investigator's belief that this will be an enriching experience for you, providing you an opportunity to reflect on past experience and offer your advice to future clinicians. The present research will contribute to the literature on therapists' experiences working with this population. Participants will play a major role in helping other researchers, social workers, psychologists, and others understand the experiences of conducting therapy in languages other than English.

If, in reflecting on your work with clients or past training experiences, you experience any discomfort recalling memories or discussing personal matters, it is important that you notify the principle investigator immediately so he may discuss these feelings with you and provide you with referrals to local counseling services if necessary. Note that the study will not pay for any counseling services recommended following participation in this study. In this event, you would assume all financial responsibility for such services.

Withdrawal: Participation in this study is **VOLUNTARY**. You may choose not to participate, and YOU MAY WITHDRAW AT ANY TIME during the study procedures

APPROVED

Subject's Initials _____

JUN 19 2013

Approved by the
Rutgers IRB

without any penalty to you. You may refuse to answer any questions with which you are not comfortable.

If you have any questions about the research, you may contact me, Daniel Braman at (732) 659-4696 or email me at dbraman@eden.rutgers.edu. You can also contact my dissertation faculty chairperson Dr. Louis Sass at lsass@rci.rutgers.edu.

If you have any questions about your rights as a research subject, you may contact the IRB Administrator at Rutgers University at:

Rutgers University, the State University of New Jersey
Institutional Review Board for the Protection of Human Subjects
Office of Research and Sponsored Programs
3 Rutgers Plaza
New Brunswick, NJ 08901-8559
Tel: 848-932-0150
Email: humansubjects@orsp.rutgers.edu

I have read and understood the contents of this consent form and have received a copy of it for my files. By signing below, I consent to participate in this research project.

Participant (Print) _____

Participant Signature _____ Date _____

Investigator Signature _____ Date _____

APPROVED

JUN 19 2013

Approved by the
Rutgers IRB

Subject's Initials _____

Consent to Audiotape and/or Videotape

You have already agreed to participate in a research study entitled: The Experience of Non-Latino Clinicians Providing Bilingual Psychotherapy (Spanish-English), conducted by Daniel Braman, Psy.M. I am asking your permission to allow me to audiotape/videotape the interview as part of the research study.

The recordings will be transcribed to ensure the authenticity of your responses, which is important for data analysis to ensure that information from the research study has been recorded accurately. This analysis includes reviewing the transcripts to discover common themes, similarities and differences across all subjects.

Recordings will include the responses that you provide throughout the interview. Please avoid mentioning names of individuals or any identifying information of clients. Any names of people places or people which are disclosed will be replaced with pseudonyms. If the interviews are video-recorded, recordings will include full facial features. I will not attach your name to any of the recordings. Instead, you will be given an identification code and a pseudonym. Only the researcher will have access to the code in a password secured database.

The investigator will keep this information confidential by limiting access to the research data. The recordings will be stored on a password protected computer and encrypted using the AES-256 encryption standard and any hard copies of transcriptions will be stored in a locked filing cabinet in a secure location. This information will be permanently erased and destroyed three years after the study ends.

Your signature on this form grants the investigator named above permission to record you as described above during participation in the above-referenced study. The investigator will not use the recording(s) for any other reason than that/those stated in the consent form without your written permission.

Participant (Print) _____

Participant Signature _____ Date _____

Investigator Signature _____ Date _____

APPROVED

JUN 19 2013

Approved by the
Rutgers IRB

Subject's Initials _____

APPENDIX E

Advertisement Emailed to Potential Participants

Hello,

I am currently recruiting clinicians for my dissertation entitled “The Experience of Non-Latina/o Clinicians Providing Bilingual Psychotherapy (Spanish-English).”

I am looking to interview non-Latina/o clinicians who have a minimum of one-year experience working with primarily Spanish-speaking clients. Interviews will last from 1 hour to 1.5 hours.

Inclusion Criteria: You have provided Spanish-language mental health services for a minimum of one year and you spoke English at home during childhood.

Exclusion criteria: You self-identify as Latina/o or have a parent from a Spanish-speaking country or you were raised in a Spanish-speaking household or culture.

You are **eligible** to participate if you meet some or all of the criteria listed above. If you are uncertain of your eligibility but wish to participate, please email or call me and we can review your eligibility.

Attached is the consent form for the study. The consent form provides basic information; please review it and let me know if you are interested and we can schedule a time to meet. Thank you in advance for your willingness to assist me in this process. If you have any questions or concerns I can be reached by phone or email, listed below.

Additionally, please feel free to provide names of other individuals you believe may be eligible to participate in this study.

Thanks,
Dan Braman

--

Daniel Braman, PsyM
4th Year Doctoral Student in Clinical Psychology
The Graduate School of Applied and Professional Psychology
Rutgers, The State University of New Jersey
dbraman@eden.rutgers.edu