

Running head: LANGUAGE AND IDENTITY IN THE BILINGUAL PSYCHOTHERAPIST

LANGUAGE IN THE PSYCHOTHERAPEUTIC PROCESS
AND THE BILINGUAL HISPANIC PSYCHOTHERAPIST'S SENSE OF IDENTITY

A DISSERTATION SUBMITTED TO THE FACULTY OF
THE GRADUATE SCHOOL OF APPLIED AND PROFESSIONAL PSYCHOLOGY OF
RUTGERS, THE STATE UNIVERSITY OF NEW JERSEY

BY

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IN PARTIAL FULFILLMENT OF THE
REQUIREMENTS FOR THE DEGREE

OF

DOCTOR OF PSYCHOLOGY

NEW BRUNSWICK, NEW JERSEY

AUGUST 2020

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LANGUAGE AND IDENTITY IN THE BILINGUAL PSYCHOTHERAPIST

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Abstract

As the demand for bilingual psychotherapists rises, understanding the effects of language and bilingualism on psychotherapy becomes increasingly important. The literature, mostly focused on the client's experience, suggests that the language used in the therapy room has an impact on the therapeutic process and relationship. This qualitative study explores the internal and interpersonal experiences of bilingual psychotherapists, adding to and deepening the pool of data about the impact of language in psychotherapy. Semi-structured interviews were conducted with nine Hispanic, Spanish-English bilingual, and psychodynamically-oriented psychotherapists. An ethnographically informed, modified grounded theory (Corbin and Strauss, 1990; McCracken, 1988) was used to analyze the data. Findings support previous research and personal accounts from psychotherapists in the literature. Most participants endorsed experiencing language-related identity differences, and a few also reported experiencing a reduction in the internal and interpersonal differences in each language over time. On average, participants indicated they felt more connected to their clients and to their emotions when they spoke in Spanish, and more professional, competent, and emotionally contained when they spoke in English. Additionally, participants reported that being trained and supervised in the language of practice improved their competency as clinicians and strengthened their ability to connect with their clients in therapy. These findings highlight the importance of increasing psychotherapists' awareness of the impact of language on the therapeutic experience. The study also underscores the need to train and supervise psychotherapy students in the language of practice.

ACKNOWLEDGEMENTS

Writing this section has been the hardest part of writing my dissertation. I wish I could express my gratitude for these people with food, but sometimes words are necessary too. Thank you, Karen, my dissertation chair, for encouraging me to tackle a manageable project and helping me see it through. I am grateful for your kindness and thoughtfulness. Thank you, Brook, my second committee member and faculty advisor, for your direct and uncomplicated advice and guidance all these years. I am deeply appreciative of your help in balancing my professional and personal goals, and always encouraging me to focus on quality of life. You really have been the best faculty advisor and mentor I could have asked for.

David, gracias. Me has enseñado a expresar mi cariño de una mejor manera y a ser más paciente. Espero que sepas cuánto te admiro y cuánto me has ayudado a lidiar con los problemas de mi doctorado a distancia. Tu corazón siempre va a ser el más grande que conozco. Mami, me hubiera gustado que hayas podido verme completar este proyecto y estar conmigo en esta etapa de mi vida. No puedo encontrar las palabras para describir cuánto tengo para agradecerte, entonces sólo te digo gracias. Pa, gracias por tu apoyo y por empujarme a empezar mi doctorado justo después de graduarme. A veces, tú sí tienes razón.

To Tom, my partner, thank you for your support, tolerance, and conviction, for your bravery and warmth. You help me remember the feats that we accomplish every day, and for that and everything else, I am grateful.

To my friends and family from home, who as bilingual people themselves, inspired me to write this project, I thank you as well. Emily, Jessica, and Rebecca – I want to convey my admiration for you as clinicians and my affection for you as honest, passionate, and funky people.

You made graduate school enjoyable. Nikki, thank you for your friendship, encouragement, and emotional and practical support throughout this process.

Finally, I would like to thank GSAPP and my cohort for making graduate school a professional and personal growing experience.

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CHAPTER I: Introduction

Statement of the Problem

The number of Hispanic¹ psychotherapy clients is on the rise (Stringer, 2015). As a result of this overall increase, much research has been devoted to exploring their cultural and clinical experience in the psychotherapy room (Dingfelder, 2005; Maramba & Nagayama, 2002; Sue, Arredondo, & McDavis, 1992). A significant area of interest for this population is that of bilingualism. A variety of perspectives, including psychoanalysis, ethnography, neurology, and sociology, have been used to study bilingualism. The literature suggests that the language of choice in the psychotherapy room impacts the therapeutic process and relationship. Mohavedi (1996) and Guttfreund (1990), among many others, highlight psychotherapists' challenges working with bilingual clients. They contend that clients whose psychotherapy is conducted in their second language may be at a disadvantage, as there is much in emotional experience that is encoded in, and therefore can only be accessed through, one's native language (or the mother tongue, as they label it). Pérez Foster (1992), a bilingual psychotherapist and researcher, connects this barrier to accessing emotions when speaking in one's second language to one's self-experiences or identities. These identities, associated with different emotions and thought patterns, are represented in and therefore communicated through the specific languages one speaks. Consequently, bilingual individuals may have different experiences depending on the language they speak. The term "language-related identities" will be used to refer to identities that are evoked by and expressed through the language they were encoded in.

¹ For the purposes of this research, the term "Hispanic" will be used to refer to individuals living in the United States who come from or whose family originated from a Spanish-speaking country. The term focuses on the language spoken by the population it describes, in comparison to "Latinx," a label encompasses individuals from Latin American countries and their descendants.

The literature on bilingualism in psychotherapy mainly focuses on the experience of psychotherapy clients, not therapists. To date, few research studies (Alonzo, 2007; Sprowls & Biever, 2002; Trepal, Ivers, & Lopez, 2014; Verdinelli & Biever, 2009) and articles (Clauss, 1998; Pérez Foster, 1996; Walsh, 2014) have focused on exploring the bilingual psychotherapist's experience in psychotherapy. The present study aims to address this gap through a qualitative, exploratory study focused on extending the current research in the area of the language-related self- and other experiences of bilingual psychotherapists. This particular study utilizes in-depth interviews with Hispanic, Spanish-English, bilingual psychotherapists, looking at their experience conducting psychotherapy in Spanish and English.

The study was designed to explore experiences specific to Spanish-English bilingualism, and, potentially, to generalize about thoughts, emotions, and feelings particular to psychotherapists who work in these two languages. While the decision to exclude psychotherapists who are bilingual in other languages limits the generalizability of findings, the study's focus allows for a more detailed, nuanced look at the particular ways these two languages shape therapeutic identity and experience. Spanish and English were chosen as the participants' two languages because the investigator is bilingual in English and Spanish and sought to develop a deeper understanding of that subgroup of bilingual clinicians. The shared bilingual experience, as Alonzo (2007) indicated, could allow "for the possibility to explore potential nuanced usage of terminology in Spanish that might otherwise not be possible if other languages were included in the study" (p. 53).

The decision to focus on psychodynamic psychotherapists was made for several reasons. Psychodynamic training involves a focus on self-awareness and self-exploration. Additionally, countertransference reactions, thoughts or feelings that psychotherapists have towards their clients, are a necessary part of psychodynamic treatment. These two components of

psychodynamic psychotherapy made psychodynamic psychotherapists ideal candidates for this project. The researcher expected that respondents would be able to reflect meaningfully upon moment to moment experiences of their sense of self and sense of others in the therapeutic encounter. Further, most of the literature focused on bilingualism and clinical psychology focuses on psychodynamic or psychoanalytic psychotherapists and clients.

The study examined four major questions: 1) Do Hispanic and bilingual psychodynamic psychotherapists experience language-related identity differences? 2) How do bilingual psychotherapists experience these language-related identity differences? 3) What factors impact the development and expression of language-related identity differences in bilingual psychotherapists? 4) How, and to what extent, do these language-related differences impact the psychotherapeutic space? It was hypothesized that Spanish-English bilingual psychotherapists would endorse experiencing language-related identity differences, and would report feeling and practicing differently in each language. Additionally, it was hypothesized that these experiences would be connected to the context and timeline of the psychotherapists' language history and the cultural factors associated with each of the two languages and the psychotherapists' family of origin.

CHAPTER II: Review of the Literature

Most Hispanic individuals living in the United States identify as bicultural or multicultural; they carry cultural practices and values associated with their family's country or countries of origin, as well as those identified as U.S. American (Valdez, 2000). Thus, most Hispanic individuals have multiple cultural identities. Of note, language and culture, though very separate concepts in theory, are difficult to separate in practice. As Schrauf, Pavlenko & Dewale (2003) remark, "anthropologists have long argued that the world we apprehend is a world labeled and theorized by the sociocultural group to which we belong...We pay selective attention to the physical and social world that surrounds us and what we pay attention to is largely shaped by the culture(s) we inhabit...In learning to speak we take on that culturally shaped world." (p. 229-230). In other words, culture, language, and perceived experience continuously influence and shape each other.

Culture constructs and is constructed by language (Norton, 1997). Citing Duff and Uchida (1997), Nida (1998) argues that the two are inseparable symbolic systems. Culture encompasses "implicit assumptions, dynamic processes, and negotiated relationships," all contained and communicated through language (p. 415). Cultural identities, therefore, are related to linguistic identities, suggesting that bicultural individuals who are also bilingual are likely to experience themselves differently depending on the language they speak (Guarnaccia and Rodriguez, 1996).

Language-related identities are developed within and influenced by significant relationships (Ogden, 1993; Pérez Foster, 1992). These interpersonal templates, containing emotions, images of self, and relationship patterns, appear to be closely linked to the language in which they were experienced. As Pérez Foster expressed, language acts as a signifier of "unique self-representations internalized at the time of respective language acquisition" (1996, p. 99). Each

language voices relationships with important others, as well as their context. Thus, bilingual individuals are likely to hold different templates of themselves within each language they speak.

Psychiatrists Marcos, Eisma, and Guimon (1977) discussed their own clinical experiences with bilingual clients and reviewed observational literature on bilingual clients in psychoanalysis. They suggested that bilingual individuals could have a different sense of self depending on the language they speak. Research in multiple disciplines aims to explain this phenomenon. Results from neurological studies indicate that bilinguals store portions of the two languages in separate brain systems (Bowker and Richards, 2004; Luk et al., 2012). Learning a second language not only results in changes to linguistic abilities, but also in changes to cerebral organization, cognition, memory, and perceptual strategies (Espín, 2013; Javier, 2007). Pérez Foster (1996, 1992) presents a myriad of correlational and experimental findings to support this claim. For example, the same word in a different language evoked different associations for bilinguals (Amati-Mehler et al. 1993). Additionally, bilinguals were found to project different character traits on projective tests depending on the language they were tested in (Findling, 1969).

A few factors have been identified in the literature that could impact bilinguals' experience of their dual identity. Age of acquisition, level of exposure, and degree of proficiency impact functional brain mapping of different languages, as noted in neuroimaging studies (Abutalebi, Cappa, and Perani, 2001). Marcos (1980) emphasized the relevance of another dimension in language and identity development. The context and timing of language acquisition can enhance the functional independence of language. Compound bilinguals, or individuals who learned languages in similar contexts or timeframes, are more prone to experience parallels in their language identities. They are more likely to feel similarly in both languages regardless of the context in which they speak them. In contrast, coordinate bilinguals, or those who learned

languages in different contexts or timeframes, are more likely to experience language independence. A higher degree of language independence, more commonly experienced by coordinate bilinguals, is likely associated with greater discrepancy between the two language-related identities in bilinguals.

Language-related identities have been noted to impact psychotherapy. Recollection and description of autobiographical events is likely to vary depending on the language used to describe the events when it differs from the language used at the time the memory was encoded (Marian & Nesser, 2000). For example, Schrauf and Rubin (2000) conducted a study with eight Spanish-English bilingual immigrants who had moved to the United States later in their life from a Spanish-speaking country. The first author, who is bilingual, conducted all testing with each client in two days separated by approximately two weeks. The conversations and testing were conducted in English on one day, and in Spanish on the other day. Autobiographical linguistic memories, those that came to them in a language (instead of an image or other sensory modality), from participants' countries of origin were more likely to be recalled in Spanish than in English. Similarly, autobiographical linguistic memories for events in the United States were more likely to be recalled in English than in Spanish. These results add to the aforementioned literature on the "mother tongue," or a client's first language, which stress that the emotional content experienced in childhood through the one's native language can only be fully retrieved through the same language (Guttfreund 1990; Mohavedi 1996). The mother tongue, learned in an emotionally-charged context, contains and can therefore access and communicate these experiences and emotions.

Clauss (1998) described the case study of a Puerto Rican, bilingual client that exemplifies this idea. The client, Ricardo, is mourning the loss of his mother. Prompted by his psychotherapist,

Ricardo shares what he would like to tell his mother, at first in English. Clauss portrayed the tone of that session as intellectual and emotionally distant. When, at a later session, Ricardo states again what he wishes he could tell his mother, this time in Spanish, he affectively invokes the relationship he had with his mother, which existed mostly in Spanish, and is able to connect to the complicated emotions he holds towards his mother and the loss. Clauss explained that “Ricardo's language shift also illustrates a language-related transference because [their] clinical work in Spanish connect[ed] him to significant losses that [were] symbolized by his language of origin” (p. 193).

Lijtmaer (1999), Marcos (1976), and Buxbaum (1942) refer to the use of a client's second language as a barrier to treatment. They claim the client's second language would evoke different and surface level associations because the connections to childhood memories are less accessible. Moreover, retrieving memories in one's second language is likely to require more cognitive and attentional demands, therefore reducing emotional involvement. A second language is generally acquired through a rational, conflict-free learning process, making the second language more likely to evoke intellectualization. Supporting this notion, therapists have remarked on an increased sense of distance from clients when the clients express themselves in their second language (Bowker and Richards, 2004; Greenson, 1950). Further, Marcos and Urcuyo (1979) portrayed bilingual clients describing themselves differently in each language. The relationship between language and emotion is also reflected in decision-making research (Costa, Vives, & Corey, 2017). Costa and his team suggest that using a second, or foreign, language increases deliberation and reduces the impact of intuition. The authors' research provides an explanation for the observation that individuals tend to intellectualize when using a second language.

Although this affective detachment, sometimes identified as resistance or a defense (De Zulueta, 1995), is often referred to as a barrier, it can also serve as a therapeutic tool (Pitta, Marcos,

& Alpert, 1978). A client's second language, if lacking in emotional engagement, can provide space from intense and painful memories, allowing their exploration from a safer position. It might help contain distressing affect and enable de-escalation and reduction of emotional intensity, when intolerable, in the therapy room. Psychologist Olivia M. Espín (2013) outlines other benefits of using a client's second language in psychotherapy. She suggests that a second language offers the client the opportunity to "create a new self," with new ways of self-expression (p. 14). A second language can also provide the client with freedom from censorships that come with the culture associated with their first language. The language choice in therapy can make certain past experiences more accessible to clients than others (i.e. those encoded in the language of treatment). Therefore, language in therapy can impact a client's transference (Clauss, 1988).

The vast majority of the literature about bilingualism's impact on psychotherapy concentrates on the client's experience. The smaller body of research that focuses on the therapist experience confirms that the psychotherapist's bilingualism also impacts psychotherapy. Stern (1993) emphasized changes in the bilingual analyst's mood and technique depending on language used. These changes in spoken language can, in turn, result in countertransference changes (Clauss, 1998; Pérez Foster, 1996; Sprowls & Biever, 2002; Walsh, 2014). There are four main research studies, all qualitative, that have been conducted to explore the language-related experiences of the Spanish-English bilingual psychotherapist.

Sprowls and Biever (2002) examined bilingual psychotherapists' perception of their language-related self-experience. The first author interviewed nine bilingual clinicians. Participants reported experiencing differences in the way they perceived themselves and in their relationships with clients when they conducted therapy in Spanish and English. Four participants reported they felt gentler when conducting psychotherapy in Spanish, and colder and more

business-like when conducting psychotherapy in English. Some participants also noted a difference in the way they viewed others and the world based on the language of treatment. The authors connected these differences to participants' cultures. They suggested that languages hold cultural "principles of relating" that influence the way psychotherapists experience themselves and behave in treatment with clients (p. 80 and p. 109). One participant in the Sprowls and Biever study reported that she felt equally comfortable and "herself" in both languages of practice at the time of the interview. She explained that she used to feel language-related differences when she first started practicing psychotherapy in both languages, but that these experiences have become more similar over time.

Alonzo (2007) interviewed thirteen bilingual psychotherapists about their linguistic experience in the therapy room. Eleven participants reported experiencing language-related identities. They stated that different parts of themselves are evoked by the language they speak. Some interviewees found themselves existing between two language worlds, feeling more comfortable, more "themselves," and more "lively" when working in their native language (p. 111). Two participants also described experiencing a difference in their self-esteem. Isabelle reported she feels "over confident" when she works in Spanish (p. 110). She is a native Spanish speaker and spoke predominantly Spanish until age 26. Moreover, she completed her bachelor's degree in psychology in Spanish. In contrast, Fannie reported she feels more confident when she works in English. Fannie is a heritage Spanish speaker. The differences in language-related self-esteem between Isabelle and Fannie may be related to the context and timing of their language learning. Alonzo posited that Fannie may also feel more confident in English because English is her language of training. Other participants felt equally comfortable with each language, but reported experiencing other language-related interpersonal and intrapsychic differences.

Participants' descriptions also supported the notion of an "intellectual function" of or emotional detachment in the second language (p. 129).

A large portion of the participants who reported experiencing a difference in self-experience also explained that this shift impacts their therapeutic style. Some examples of the stylistic shifts listed included a change in use of body language, tone of voice, boundary setting, therapist neutrality, and emotional expression. A few of the participants who reported experiencing language-dependent identities denied experiencing an impact on their therapeutic style. Finally, two participants, one of whom was identified as a compound bilingual, did not report any awareness of differing language-related identities. Alonzo's data support the premise of the current study, suggesting some bilingual clinicians experience language-related identities, and that this phenomenon could impact their therapeutic style. It also corroborates Marcos' theory (1980), suggesting that time of language acquisition could be a factor to consider, given that the compound bilingual, the participant who learned the two languages at the same time and possibly within the same contexts reported feeling the same regardless of the language he speaks.

Verdinelli and Biever (2009) also conducted a qualitative study to phenomenologically examine the experiences of Spanish-English bilingual psychotherapists. They interviewed 13 therapists, asking about their personal and professional language development and use. When reporting their results, the researchers separated native from heritage Spanish speakers, noting differences and similarities between both groups. Heritage Spanish speakers stated they felt more self-aware when conducting treatment in Spanish, while native Spanish speakers reported feeling more self-aware when conducting treatment in English. Participants also discussed their experience of living in two language-related worlds, descriptions that resemble the notion of language-related experiential differences. Heritage speakers listed school versus home as their two

worlds. Native speakers, in contrast, noted they lived in two other worlds: their home country and the U.S. Both groups indicated that they connected more easily with Spanish-speaking clients than with English-speaking clients. Finally, participants in this study also reported feeling aware of their limitations in providing services in a language other than their language of training.

Castaño, Biever, González, and Anderson (2007) examined the service delivery experiences of Spanish-English bilingual psychotherapists, focusing on their training and perceived competence to provide services in Spanish. They used a 12-item questionnaire developed to assess the experiences of psychotherapists performing mental health services in a language other than English, their language of training. Over half of the 127 participants reported they had not received any training to provide mental health services in Spanish. The participants who did receive training in providing Spanish services received courses about providing Spanish language services (16%), supervision of Spanish language services, which was not always conducted in Spanish (39%), and attended workshops about providing Spanish language services (28%). Additionally, participants reported they felt concerned about their use of vocabulary in Spanish (52%), about their ability to apply concepts and theories in Spanish (58%), about their conversational proficiency (42%), and about their grammar (39%). These results indicate that language of training impacts the provision of psychological services in another language. Participants specifically expressed difficulty with transferring material (vocabulary, concepts, and theories) learned in English to their work in Spanish. This study highlights the implications of language of training.

In articles that reflect on their personal experiences as bilingual psychodynamic psychotherapists, Pérez Foster (1996), Clauss (1998), and Walsh (2014) have explored their language-related identities and their influence on the psychotherapeutic process. Pérez Foster

highlighted her intrapsychic and experiential duality, her self-experience shifting as she changes languages. Her experiences seem to mirror those of bilingual clients. She explained she possesses different representations of self and others organized around the language in which they were encoded.

Clauss (1998) referred to the “dual templates” Pérez Foster described in her 1996 article and embarked in her own self-exploration through an article about her language-related self-experiences. She explained that she, like other bilingual psychotherapists, experiences a dual sense of self, with two distinct ways of thinking, feeling, emoting, and experiencing and interacting in the world. She then discussed how these differences impact her therapeutic style. Clauss’s stylistic shifts include joking around, being more animated, and being more prone to gesticulating when practicing psychotherapy in Spanish. In addition, Clauss stated she feels more professional and formal in English. In line with the reviewed literature, she connected these and other stylistic shifts to cultural terms, phrases, concepts, and experiences held in each of her two languages of practice. For example, for Clauss, her perception of a decreased level of formality when she practices in Spanish stems from the more fluid boundary of professional relationships that is traditional in many Latin American countries, as compared to the U.S.

Walsh (2014), a bilingual clinical psychologist who practices in English and Hebrew, also wrote about her experience as a bilingual analyst. She found the identity evoked by her native tongue, English, to be more distanced and cautious with her clients, due to the more painful emotional content it allows her to access. In her second language, Hebrew, she feels freer to help her clients explore deeper emotional states and more comfortable accessing those spaces with them. Walsh also pointed to the language of training as a relevant element for language-related self-development. She refers to her English-speaking self as her “pre-therapeutic frozen self,” a

self that did not develop along with her therapeutic identity in Hebrew, her language of training (p. 64).

Developing a greater understanding of the factors that influence bilingual psychotherapists' language-related identities could greatly benefit both psychotherapists and their clients. Further, if these patterns are as pervasive in bilingual clinicians as the literature suggests, raising awareness could encourage clinicians to reflect on their own experience. Increased self-awareness could in turn equip them with greater flexibility and choice in their therapeutic style. As Walsh (2014) explained, "by understanding in what language system we and our patients are operating and the dynamics...involved, we can better understand the transference and countertransference dynamics in the therapy" and make more conscious intervention choices around them (p. 60).

CHAPTER III: Methods

Rationale

The purpose of this study was to extend and deepen the understanding of the bilingual clinician's language-related identities and the impact of these identities on the therapeutic process. The study employed a qualitative research approach (Corbin & Strauss, 1990), focusing on hypothesis generation to produce direction for further research. This approach allows for exploration and understanding of patterns, emphasizing themes as the basic unit of analysis.

Participants

Selection criteria.

In order to be eligible for this study, participants had to meet the following criteria: a) licensed practicing psychotherapists or advanced predoctoral or postdoctoral psychotherapists practicing under the supervision of a licensed psychotherapist; b) bilingual (English-Spanish); c) self-identified as psychodynamic psychotherapists; and d) conducted individual psychotherapy in each language (English and Spanish) with at least two (2) clients in each language (for longer than 3 sessions each).

Recruitment.

Participants were initially recruited through postings on psychological listservs (the New York State Psychological Association, the New Jersey Psychological Association, and the Latino Mental Health Association of New Jersey). This recruitment technique yielded only two subjects. The investigator recruited the remaining participants via word-of-mouth recommendations from bilingual colleagues and through the "snowball technique" (Potter, 1996, p. 107), by which participants provided the investigator with other possible participants to contact. All participants were briefly screened by the principal investigator. Once eligibility was established, participants,

even those first approached in person, were provided with the recruitment e-mail (Appendix A). The investigator then asked them about their interest in participating in the study, and set a meeting time and date for the interview.

Procedure

The primary investigator conducted semi-structured interviews in the professional offices of the licensed social workers and licensed psychologists. The two interviews with the doctoral students were conducted in a private and quiet location chosen by the participants: one in therapy room of a community clinic where the participant works, and one at the participant's home office. At the time of the interview, participants were provided with a consent form (Appendix B) and were asked to sign it after being given time to review it thoroughly.

The interviews were conducted in English for a few reasons. The dissertation committee was composed of monolingual, English-speaking faculty members. Moreover, the study was developed to meet a requirement for an English-language, Doctor of Psychology program. English was therefore chosen as the language for the interview to not only ease the transcription and writing process, but also to be able to report participants' experiences in their own words.

The interview followed the questions listed on Appendix C. The questions were based on the literature review and designed to provide an organizing guide for the interview, without forcing participants into specific or closed-ended answers. The open format allowed participants to offer rich and personalized information. The investigator piloted the interview questions with a doctoral candidate in her program to test the interview length and kinds of responses evoked by the questions. Through this pilot, and a conversation with the interviewee, the investigator decided to modify the question order and delivery. Three questions, which asked, "Would you say that your languages and your dream life are related?" and "When do you dream in Spanish? When do you

dream in English?” were provided ahead of time to make sure that participants could have an answer prepared, given that dream content and language of the content can be hard to recall in the moment. Their answers to that question were collected in person, once they completed the informed consent form. The rest of the questions were asked in person to reduce bias.

Interviews lasted on average 45 minutes, ranging from 31 to 65 minutes. All questions from the Interview Guide (Appendix C) were asked and addressed during the interview, but the length and depth of answers varied. The interviews were audiotaped with the consent of the participants and then transcribed through the use of an automated transcription service. The transcription service encrypts the audio files and transcripts and stores them securely online. The stored files were deleted by the transcription company after the project terminated, at the request of the investigator.

Treatment of data.

All participants were assigned a pseudonym that was attached to their data. The document pairing participants to their assigned pseudonym was kept under a locked cabinet, and was only accessed by the principal investigator. All paper data was kept in a separate locked cabinet that was only accessed by the principal investigator. The audio recordings were deleted from the recording device once they were moved to a password-protected computer, where they were stored in separate password-protected files. All de-identified electronic data was stored in separate password-protected documents in a password-protected computer.

The investigator reviewed the software output thoroughly while listening to the interview recordings to ensure accuracy. For confidentiality, the investigator changed all identifying information to pseudonyms or labels (for example, a specific city name was replaced by “CITY”). As explained to the participants, only the principal investigator and the two dissertation committee

members reviewed the complete transcriptions. All audio files, transcriptions, and identifying information that were securely stored during the investigation will be securely shredded, destroyed, and deleted three years after the completion of the study following IRB protocol.

Data Analysis

The data was created and analyzed following the three types of coding outlined for Grounded Theory research by Strauss and Corbin (1990), in combination with the guidelines to review data from a long interview outlined by McCracken (1988). The data obtained from the interview transcriptions was continuously evaluated for coding patterns throughout the data collection process to revise hypotheses and guard against bias. During this process of data creation, coding, and analysis, themes that appeared repeatedly in different interviews were marked as relevant and were added to the evolving theory. The following stages were revisited multiple times throughout the data coding and analysis process.

1. Open coding: Coding involves breaking the data down to groups that fit conceptual labels. These labels identify areas of the data that are similar to or different from each other, according to that category and its specific properties. Ambiguities in the data at this stage of the coding can be resolved by performing further interviews; data will be analyzed as it is created to then guide further data collection.
2. Axial coding: Categories continue to be developed and tested against the data, looking for different indications of them and their subcategories. These categories and subcategories are considered temporary, and are continuously compared with the incoming and previously-created data in order to verify them or determine if they should be revised or discarded. Data revisions and discarding does not happen based on a single disagreement. A discrepancy can suggest the existence of a “conditional relationship,” meaning that a

situation occurs only under certain conditions (p. 14). Similarly, verification of categories and their hypotheses requires a thorough inspection of the data.

3. Selective coding: Categories are unified under core groupings that signal central phenomena or themes for the study. Themes highlight “central thread[s] that run through the data” (Richards & Morse, 2012, p. 135). At this stage of coding, diagrams are drawn to assist with category integration.

Researcher

The researcher, in this case also the author and primary investigator, is the main instrument for data collection and analysis in qualitative research (Glaser & Strauss, 1967). The qualitative approach to research is keenly aware of and sensitive to the impact of the self of the researcher as the prism through which the researcher views the data. It is therefore imperative for the investigator to remain aware of this notion of background that shapes the inquiry and its conclusions. The investigator’s background and experiences, with a special focus on their relevance to the study, are described below.

I am a native Spanish speaker, born and raised in Peru. My home life was in Spanish, but my family members sometimes also spoke French. I was informally exposed to English since age three, and began taking English classes when I was eight years old. I later strengthened my English-speaking skills by completing my middle and high school education predominantly in English. I also received an education in Spanish, completing courses in middle high school taught in Spanish, about Spanish grammar, literature, and Peruvian history. I immigrated to the U.S. at 19. The programs I attended for undergraduate and graduate studies were both in the U.S. and taught in English. I am fluent in both Spanish and English.

The idea for this study arose from my own experience as a bilingual clinician and my interactions with other bilingual psychotherapists. I have perceived small differences in my felt experience growing up in different bilingual communities (English and Spanish at school and English, Spanish, and French at home). I first began experiencing more noticeable differences in my self-experience when I started providing psychotherapy in Spanish and English. I was working at a school-based youth program, providing individual psychotherapy in Spanish to a few adolescents. I felt more vulnerable conducting psychotherapy with these Spanish-speaking clients, and more competent with my English-speaking adolescent clients. I began to notice and feel curious about other language-related patterns in my felt experience when I practiced psychotherapy. I have sometimes felt divided, as if parts of my experience are missing when I exist in one language or the other. I wondered about these differences, the experiences of other bilingual clinicians, and the possible implications of these differences.

While I developed this study, I was providing mental health services in Spanish and English. In Spanish, I provided individual and family psychotherapy and conducted forensic evaluations for asylum seekers. In English, I conducted individual and group psychotherapy and completed psychodiagnostic and neuropsychological assessments. For two years during my graduate training, I also worked as an English-Spanish interpreter on forensic evaluations.

CHAPTER IV: Results

Demographics

Three male and six female participants were interviewed. The participants' ages ranged from 29 to 63, with a mean of approximately 45 years old and a median of 44 years old. Three participants were born in the U.S., and the remainder were born in other countries and moved to the U.S. at different stages of their lives. Two participants emigrated from South American countries, one from a Central American country, two from the Caribbean, and one from a North American country. They immigrated to the U.S. between the ages of 6 and 33. Four of them moved with their families; two moved alone for their education.

Two participants were advanced students in clinical psychology doctoral programs and had clinical experience working in both languages. All participants had a master's degree and/or a doctoral degree, and seven were licensed in their field. Six participants were clinical psychologists or trainees in that field, and three were licensed clinical social workers. The participants' years of experience in the field, including the years during and after their degrees ranged from three to 26, with a mean of approximately 13 years and a median of 12 years.

All nine participants were fully bilingual in English and Spanish. One participant was raised in a bilingual household, hearing and learning both English and Spanish since birth. In contrast, the other eight participants were native Spanish speakers who learned English in a class or at school.

Participants

All identifying information has been removed to protect the psychotherapists' anonymity. The names used for each participant are pseudonyms.

Alba.

Alba is a third-year doctoral student in a clinical psychology program. Her language of training is English. She sees clients under the supervision of licensed psychologists in different settings, and works with monolingual English-speakers, monolingual Spanish-speakers, and bilingual clients. She identified psychodynamic theory, specifically object-relational and relational theories, and Dialectical Behavior Therapy as her main psychotherapeutic orientations.

Alba immigrated to the U.S. from a South American country with her family at age 12. Alba is a coordinate bilingual. She is a native Spanish speaker and only started learning English after her family's transition. She learned English through interactions with her new community members, feeling like she had been "thrown in the deep end" and forced to learn the language out of necessity. Additionally, she learned English at school. She was placed in an ESL, or English as a Second Language, class instead of a mainstream English class.

Currently, Alba's dominant language is English. She lives mostly in English, and says she has a more extensive vocabulary in English than in Spanish because her advanced schooling has been in English. Alba speaks English with her husband, a native Spanish-speaker, and he speaks to her in English and Spanish, though he feels more comfortable speaking in Spanish. Alba also shared that she is trying to speak more Spanish at home, as she wants to strengthen her language skills. Alba also speaks in Spanish with some friends, who are monolingual Spanish-speakers. Alba speaks in English with her colleagues, professors, and her own therapist. In her own therapy, she sometimes uses Spanish terms or words and then attempts to translate them to the best of her ability. Her therapist understands some Spanish and is able to remember meaningful words from their treatment, a pattern that seems to have had a powerful and positive effect on their relationship.

Lucía.

Lucía is a practicing licensed clinical psychologist who works in a private practice and college counseling center in a northeast state in the U.S. Her language of training was English. Most of her pre-doctoral work was in Spanish, with some work in English. Her post-doctoral work, however, has been predominantly in English, with some work with monolingual Spanish-speakers. Lucía has worked with children, young adults, and adults, with a wide range of clinical diagnoses, including eating disorders. She identified psychodynamic theory as her main psychotherapeutic orientation.

Born and raised in a northeast state in the U.S. of South American immigrant parents who spoke only Spanish at home, Lucía is a heritage speaker, learning Spanish at home through her interactions with her parents. She started officially learning English at age four or five in school. She hypothesizes she must have heard and spoken the language with her two older siblings who learned English at school before her, and with members from her community.

Lucía currently lives in both English and Spanish. She speaks English with her husband and two daughters and Spanish primarily with her family of origin, including her mother, who speaks English but “not well,” and her siblings. She has felt more comfortable speaking in English throughout her adult life and thinks more in English. All the dreams she can remember have a narrator or dialogue in English. However, Lucía feels closer emotionally to Spanish, labeling it her “home language” and her “family language.” She also suspects that she had more dreams that incorporated Spanish when she was younger.

Miguel.

Miguel is a licensed clinical social worker (LCSW) working at an outpatient hospital setting doing psychotherapy and case management with monolingual Spanish-speakers,

monolingual English-speakers, and bilingual clients. His language of training was English, but most of his work during his training (approximately 70%) was with monolingual Spanish-speaking clients. He identified psychodynamic theory as his main psychotherapeutic treatment orientation.

Miguel was born and raised in a northeast state in the U.S. His parents and family members were from a Caribbean country. He is a heritage Spanish speaker, growing up in a Spanish-speaking household and officially starting to learn English at age five when he began school. He also lived in his parents' country of origin "on and off" from ages five to eight. In that country, he attended school for about one year and a half, where all of his classes were taught in Spanish.

Miguel currently lives in English. He speaks English with his colleagues, friends, and family members including his wife and children. He speaks Spanish with his mother and siblings. In the past, he has attended his own therapy and the treatment was in English. Additionally, Miguel only dreams in English and cannot remember ever dreaming in Spanish.

Antonella.

Antonella is a licensed clinical psychologist working in an outpatient hospital setting. Her language of training was English and the prevalent orientation in her training was psychodynamic theory. Her pre-doctoral, clinical work was both in English and Spanish. She now works mostly with monolingual English-speaking clients, and some monolingual Spanish speakers and bilingual clients. Throughout her career as a psychologist, Antonella has also been a part of a treatment team at an inpatient unit and at a counseling center. She identified her treatment approach with clients as eclectic.

Antonella was born and raised in a bilingual household in a northeast state in the U.S. and is a compound bilingual. She learned English and Spanish simultaneously, but her first words were in Spanish. Her mother, who immigrated to the U.S. from a Caribbean country at age 19, is

predominantly a Spanish speaker. Antonella said she spent most of her pre-verbal years with her mother who stayed at home with the children while her father worked. Her mother spoke to Antonella and her siblings in Spanish. Her father is predominantly an English speaker. He emigrated from the same Caribbean country as Antonella's mother at age four. He communicated with Antonella's mother in Spanish and with his children in English. Though Antonella's schooling was in English, her home life involved speaking both Spanish and English. Antonella's community was mostly composed of Latinx immigrants from diverse Spanish-speaking countries. The majority of her childhood friends, therefore, were bilingual in English and Spanish. Their main form of communication occurred in Spanglish, a hybrid language combining words, idioms, and grammar from both languages.

Currently, Antonella lives in both languages. She speaks English with her husband, friends, and colleagues. She speaks Spanish mostly with her mother, with whom she speaks on a daily basis, but also has a few friends with whom she communicates in Spanish or Spanglish. Additionally, Antonella speaks to her daughter in both English and Spanish. Antonella's personal therapy was in English, but she sought out a bilingual, Spanish-speaking, Latina therapist. She wanted to have the option to describe her experience using Spanish terms and believed she might feel better understood by someone who shared her ethnic label. Antonella mostly used Spanish in her therapy to quote interactions with her mother or discuss food or cultural concepts. Antonella dreams predominantly in English. Her dreams include Spanish dialogue or narration when they include her mother. Moreover, she does not think in Spanish often; her "intellectual, cognitive process is in English."

Cristina.

Cristina has a doctorate in clinical psychology and is working as a postdoctoral fellow at a medical center. She works with monolingual English and Spanish speakers, and bilingual clients. Her predoctoral training was in English, including courses and supervision, though she worked with monolingual Spanish-speaking clients and had Spanish-speaking supervisors. Cristina indicated that her supervisors were culturally sensitive to issues that were relevant to her clients but did not conduct supervision in Spanish. Cristina has provided mental health treatment at both outpatient and inpatient settings, for low and high functioning clients of diverse gender identities. She identifies her main therapeutic orientation as both “post-Freudian psychodynamic” and integrative.

Cristina was born in a country in the Caribbean and immigrated to the U.S. at age seven with her family. A native Spanish speaker, she learned Spanish from birth with her family and later at school. She learned English when she moved to the U.S. Her parents spoke English “well enough to communicate with people” but not fluently. She assumes she heard English in movies prior to her move.

Currently, outside of her clinical practice, Cristina lives in English. Her self-concept is in English. She speaks English with her friends, colleagues, and sister. She can “count in one hand” the people with whom she speaks Spanish: her parents, her family members from her country of origin, and some neighbors. She also listens to music and watches movies in Spanish. Additionally, Cristina mostly dreams in English. Her dreams in Spanish often involve her country of origin. She also has been working on understanding when she dreams in Spanish, and theorizes that the language shift in her dream life could be related to emotional content associated to Spanish in her work or personal life.

Pablo.

Pablo is an LCSW. He works at an outpatient medical center providing therapy, case management, and other services to monolingual Spanish and English speakers, and bilingual clients. He first obtained a bachelor's degree in his country of origin in South America. He then obtained a master's degree in field not related to mental health and a second master's in social work, both in the U.S. His training in social work was in English, in terms of coursework and supervision, but he worked predominantly with monolingual Spanish-speaking clients. His work history has involved extensive training and psychotherapy with individuals who struggle with different addictions. He describes his style as a therapist and counselor as drawing from psychodynamic theory and addiction treatment principles.

Pablo was born and raised in a country in South America. He is a native Spanish speaker and learned English in different stages of his life. He was exposed to basic words and phrases in English throughout grade school. He then attended two different institutes in his home country to strengthen his English language skills at age 18 and between ages 23 to 25. He immigrated to the U.S. at age 27 and completed a six-month course in English as a Second Language at a local university. He started at the highest level due to his previous English training.

Currently, Pablo lives primarily in English. Outside of the office, he speaks English with friends, colleagues, and people in his neighborhood. He speaks Spanish with some friends and his family members. His immediate and extended family are fluent in English, so he sometimes uses terms or phrases in English when he speaks with them as well. Moreover, Pablo attends a monthly book club in Spanish, where he discusses Latin American literature with friends for a few hours at a time. Pablo has attended his own psychotherapy in both English and Spanish. He worked with two therapists in Spanish, one in his home country and one in the U.S., and the rest of his treatments

were in English. He perceived his treatments in English and in Spanish to be equally helpful but different. Pablo has dreamed in both English and Spanish, but struggled to identify patterns of when the dreams occurred in each language. He suggested he might be dreaming more in English than in Spanish at the moment but that the language that pervaded his dreams felt random.

David.

David is a third-year doctoral student in a clinical psychology program in the U.S. Previously, he obtained a master's degree in psychodynamic psychotherapy in a Spanish-speaking country, a program that lasted three years. He practiced psychotherapy in Spanish for approximately four years before starting his second graduate degree. In the U.S., David's training, supervision, and therapeutic practice are in English, though he has provided psychotherapy in Spanish in the U.S. as well. He has worked with clients who identify as Latinx and/or U.S. American. David describes his current therapeutic orientation as mostly psychodynamically oriented, and evolving based on his most recent studies and exposure to more cognitive-behavioral approaches.

David was born and raised in a Spanish-speaking, North American country, and is a native Spanish speaker. He has also lived in Europe with his mother as a child for a few years and has visited his father in the U.S. throughout his life multiple times for short periods of time. David is a native Spanish speaker. He began to study the English language at around seven or eight years old. At this time, he took English classes with a private teacher once or twice a week. He had a "decent" command of the language by age 15. His high school education involved "a lot" of classes in English. After completing his high school studies, David attended college in the U.S. His command of English improved drastically during his undergraduate studies, to the point where he felt more comfortable in English than in Spanish during this period of his life.

Currently, David lives in both languages. He speaks English with a large part of his community, his classmates, and his friends. He speaks in Spanish with his wife, his daughter, his immediate and extended family, and some classmates and friends. He dreams in both English and Spanish, but probably more in Spanish, and has not noticed any patterns of when he dreams in each language. In the past, when he attended his own therapy, the treatment was conducted in Spanish.

Isabella.

Isabella is an LCSW, working at an outpatient hospital setting doing psychotherapy and case management with monolingual Spanish speakers, monolingual English speakers, and bilingual clients. Her language of training and supervision was English. She was supervised by Spanish-speaking, Hispanic supervisors who spoke English when supervising cases that involved therapy, counseling, and/or case management in Spanish. Some Spanish-speaking supervisors would use Spanish during supervision when they discussed food, culture, and/or social matters, but strictly English when discussing cases and clinical material. Isabella has provided mental health services for adult and geriatric clients. She described her treatment approach as eclectic and psychodynamically interpersonal.

Isabella was born in a country in the Caribbean, and immigrated to a northeast state in the U.S. with her parents and siblings when she was seven years old. Her family's emigration occurred during a tumultuous dictatorship in her country of origin. She explained that only well-educated citizens and their families were allowed to leave the country to avoid "embarrassing" the government abroad. Her immigration experience to the U.S. is therefore very different from that of her immigrant, Spanish-speaking clients, who often have a lower educational background and fewer resources.

Isabella is a heritage Spanish speaker and learned Spanish at home, with family, and in her childhood community. She learned English when she immigrated to the U.S. in both a public-school system and in Catholic schools. Her community in the U.S. primarily spoke English but one other family in her building, the superintendent's family, spoke Spanish. Currently, Isabella lives bilingually. She speaks English with colleagues, friends, and acquaintances. She speaks mostly in English with her daughter but sometimes also uses Spanish. Similarly, she "flip flops" from Spanish to English with her siblings frequently. With her parents and with some people in the neighborhood where she works, Isabella speaks in Spanish. In the past, when she attended her own therapy, she spoke English in treatment.

When asked about her dream life, Isabella explained that most of her dreams are in Spanish and connected this pattern to her internal life. Isabella's internal narrator is in Spanish. She tries to do clinical and personal readings in Spanish. She also tries to search for information online in Spanish, especially when she has to educate her monolingual Spanish-speaking clients about a specific topic with which she is not familiar, so that she can learn the terminology better. For Isabella, speaking Spanish properly is important in general and even more so when she speaks with Spanish-speaking colleagues from other countries.

Sofía.

Sofía, a clinical psychologist, works in an outpatient hospital setting providing group and individual psychotherapy for English- and Spanish-speaking and bilingual clients. She works with different populations, including adults, college-age students, families, and individuals with depression, obsessive-compulsive disorder, anxiety, posttraumatic stress disorder, borderline personality disorder, postpartum depression, and psychosis.

Sofía's language of training was English. She received supervision in Spanish for clients who were being treated in Spanish. She had several Latinx supervisors who were born outside of the U.S. and chose to supervise Spanish-speaking cases in Spanish. She describes her psychotherapy orientation and treatment approach as psychodynamic with a multicultural framework, integrated to individualize the therapy according to her clients' needs.

Born in a country in Central America, Sofía immigrated to a northeast state in the U.S. with her family at age 11. She is a native Spanish speaker, learning Spanish from birth and throughout her childhood at home and in school. She learned English when she was 11 years old in school. Currently, Sofía lives in both Spanish and English, but predominantly in English when she is in her state of residence. She uses both languages at work and at home, with her husband and her son. She also speaks English with her friends and sometimes with her sisters. Sofía speaks in Spanish with her neighbors, a few friends, and her family of origin, which includes her sisters, mother, grandmother, and aunts. When she attended her own psychotherapy treatment, it was conducted in English.

Sofía now mostly dreams in English, though she dreamt in Spanish in the past. She remembers the first time she had a dream in English, in her early adolescence, an event that she remembers people equating with becoming fluent in English.

Interview Themes

The themes that emerged from the data will be reviewed in this section, and were entitled Language-Related Identity Differences and Integration; Self- and Other Experiences in Spanish; Self- and Other Experiences in English; Language Choice in Training and Supervision; and the Possible Impact of Language-Related Differences on Psychotherapy.

Language-related identity differences and integration.

This first theme encompasses accounts from the psychotherapists where they explain the differences they experience in each language. At the start of this study and throughout the questions, the term “language-*based* identity differences” was used to learn about and understand these experiential and emotional differences. After analyzing the transcripts, however, the term “language-*related* identity differences” was chosen to replace the former one to fit more accurately the participants’ experience and description of this phenomenon.

When asked about experiencing language-related identity differences (referred to as “language-based identity differences” in the question), eight participants indicated that they currently experienced them or had experienced them in the past. These differences were experienced in varying degrees by the participants. The descriptions of participants who endorsed experiencing language-related differences clustered under three main categories, which will be expanded on in the three sub-themes below.

Experiences lost in translation.

Alba stressed throughout her interview that some developments she accomplished in one language did not translate to her experiences in the other language. For example, she noted that some traits, like her emotional intelligence, felt developed in English and relatively stunted in Spanish. She referred to the time when she moved to the U.S. as the point when her emotional development in Spanish might have stopped:

“Maybe it's almost as if in Spanish, I start developing my emotional experiences up to a certain level...I wonder if my emotional IQ in Spanish also is the equivalent of a seventh-grade level or sixth-grade level.”

Alba also discussed how learning about concepts and having experiences in one language can affect these same experiences when they arise in the other language. Her description of her supervisory experience with an English-speaking supervisor highlights the nuances of the intersection between language and past and present experiences, nuances that were woven into other participants' social, professional, and clinical experiences throughout their interviews:

“I'm going through a very difficult moment with one of my supervisors right now and I've only been able to really think about that experience in English, even though he's pulling on some strings that are based on Spanish [experiences]. He [the supervisor] is playing on my father's strings. My relationship with my father was in Spanish. My treatment is in English. I mostly speak English with [the supervisor]. Even though he's pulling on my Spanish emotional experiences from my past, so far, I have only been able to make sense of them in English because that's the way I can describe what I'm feeling most accurately...All of the different dynamics that are going on with this guy...I can easily describe it in English. I think I would stutter a lot if I tried to put all that into words in Spanish. And I have. I've tried to explain the situation to my husband [in Spanish], and I can't...I'm sure that if I had talked about that process with [the supervisor] in Spanish, I would be able to communicate to my husband [in Spanish] very easily what happened. But because it's happening in English...the translation of the what happened at a concrete level and also what was happening for me emotionally, that would take a lot to transfer over to Spanish...Because you're not only translating the content, the language content, but you're also translating the emotional content.”

Alba expands her argument by using her religious development as another example. Alba's religious upbringing took place in Spanish and, although she has attempted to pray in English, she continues to find a more genuine spiritual connection to a higher power in Spanish:

“What I'm trying to say is God exists in Spanish for me. And I don't know how to find him in English.”

This religious difference has also impacted her way of practicing, which will be outlined in more detail under the fifth theme.

Interactions between language-related identities

Two participants reported they have noticed an interaction between their language-related identities. Alba reported she has experienced her two selves—the one associated with her experiences in the U.S. and English, and the one associated with her experiences in her country of origin and Spanish—as interacting with each other:

“I think being bilingual and being bi-cultural gets really complicated. For example, I was a gender studies minor in college. So, I learned all about globalization and politics and sex and sexism and all the isms in English. And when I go to [my country of origin] and I notice all of those isms...it feels very incongruent with my [U.S.] American side and as much as I try to think: “this is the way [my country of origin] runs. This is the way that Latin Americans are here,” it still feels like I can't reject it as much as I reject it here [in the U.S.] because I was taught to reject it here [in the U.S.] and I wasn't taught to reject it there [in her country of origin]. So it feels like I'm asking [the] culture [in my country of origin] to be different and I don't know if I'm in my right to because that's the way that the culture is...I was trained to think critically here not there... Sometimes I have this problem with my husband. He says, "You're over-thinking things, you're over analyzing what people

are saying. You can't expect people here to be as open minded as you are." And I started to have this rejection toward certain parts of what it means to be [a person from my country of origin] because it's so incongruent with my values and morals and beliefs that I bring from here."

Cristina highlighted a similar interaction between the identities associated with her experience in the U.S. and her country of origin:

"When I first started externing here...When I was at meetings, I used to pronounce my name with how it sounds in Spanish... Even in meetings where everyone speaks English and they have no idea what you're saying because there's a slight accent. And I realized I stopped. The more pressure and the more evaluation there was...the closer I got to internship, to Postdoc [later stages of her professional development], I started pronouncing my name in meetings how [U.S.] Americans pronounce it. It just feels like I'm participating in oppressing a certain part of me."

Possible factors impacting language-related differences.

For Alba, the identity differences she experiences when she practices in English and in Spanish are partly related to her educational history. Alba spoke Spanish in school, and then continued her schooling in English when she moved to the U.S. The difference in language in these two separate stages of her education seem to have contributed to the creation of two distinct language-related identity experiences:

"My [U.S.] American-[country of origin] 29-year-old self is highly educated and my 29-year-old [country of origin]-[U.S.] American self...the side [from my country of origin] ...stayed stuck at...the sixth-grade level. So, if I'm seeing myself just as [U.S.]

American...That's the side that's getting a [doctorate] and then [the side from my country of origin] is the side that stopped getting an education at 11 years old.”

David suggested that, for him, the language-related identity differences he experiences in his personal and professional lives are related to his cultural experiences:

“I’m sure that different parts of me come out in different languages... There's a different sense of the cultural reference with which you identify in each language.”

Integration of language-related identity differences.

Lucía, Isabella, and Sofía reported that the differences they feel when practicing psychotherapy in English and Spanish had become less drastic, or had integrated, with time. For Lucía, becoming “more comfortable” with herself professionally and socially in both languages, as well as living and practicing in both languages, has stimulated the integration of possible differences she experienced when she first started practicing psychotherapy in each language. At first, she felt more comfortable in Spanish:

“I think earlier on in my training I felt like [my level of comfort]...was coming into the room more readily in Spanish. I would just be a little more casual, a little more myself, just a little more familiar [in Spanish]. And while I would say that that's maybe still happening to some extent, I see that coming into my work when I speak in English as well [now].”

Similarly, Isabella felt more “split” when she first began learning English. For her, this split is related to two factors: the added level of cognitive demand and the internal narrator she had when she navigated English as a new language. Isabella explained that these two components distanced her from her experiences in that new language:

“The Spanish-English Isabella? Did I ever feel split? Maybe early on. When I was trying to learn English, my world was all in Spanish. So, trying to navigate the English [world]

was a process. And, yes, then at that point, you're translating and you're trying to figure out what's the right word. How do you say it in English? How do you conjugate words? Then, after that, it's natural. So, in my adult life, I never thought about that [feeling split].”

Sofía first said she does not experience language-related identity differences in her professional life. Later in the interview, she suggested that a shift similar to the one reported by Lucía and Isabella might have occurred for her. For Sofía, this integration could have partly occurred because of her increased experience practicing in both languages:

“I mean, [I don't feel differences when I practice in Spanish], perhaps not as much now than when I was first starting. I mean, maybe just because I just have more experience, *period*...because I'm more experienced, I'm able to just be more present in both languages without having to think about, “How do I say something?””

Self- and other experiences in Spanish.

This theme emerged from the patterns of experiences that participants had in Spanish in regard to themselves and other individuals. All participants described having a strong emotional connection towards the Spanish language and to other people, both professionally and personally, when they spoke Spanish with them.

The experiences described by participants that fall under this theme will be described through the following four sub-themes: participants' experiences of emotions in Spanish, use of Spanish to express emotions to others, quality of interpersonal experiences of intimacy in Spanish, and participants' hypothesized factors impacting these experiences (native language, childhood experiences, shared values and cultural experiences in a dyad, childhood experiences, and minority status).

Experiences of emotions in Spanish.

Participants expressed, in different ways, feeling more connected to their emotions and to people when they speak in Spanish. Lucía compared her emotional experience expressed in English to her emotional experience when speaking Spanish:

“Sometimes English feels a little more removed, a little less emotional. And so, when I find myself maybe a little more... full of certain emotions. It's like I want to say it with the emotion that it holds...And English words tend to not really convey that as well...I think it's just the nature of what those languages represent to me. So, I think Spanish is still much more intimate for me, you know. It's the language I speak with some of the people closest to me...So it feels closer. I feel closer to people in that language. I certainly... I married someone who doesn't speak Spanish, so I certainly can feel close speaking in English. But it's a different experience. It's a much more controlled kind of feeling or experience of expressing.”

Pablo used the word “visceral” to describe his experiences in Spanish, comparing it to a more “technical” and “cold” experience in English:

“Sometimes I feel that there are certain ways of saying certain things in Spanish that are far more to the emotional essence of what you wanted to say. In English is...it can be very technical...Sometimes, there are examples where it feels too cold, or too, you know, structured. When in Spanish it feels so visceral and dirty...”

Cristina illustrated a similar connection to her experiences through the Spanish language:

“There's something of what I think of as being very lively, vibrant in some way...It's something like "effervescent..." [It] feels more tangible. Or just more like you're living as opposed to thinking...I *think* in English...I don't know that I *feel* in Spanish. But when I

think of feeling...It feels more like what I feel like when I think of Spanish” (emphasis added).

Use of Spanish to express emotions to others.

Both Alba and Sofía also stated that they are more likely to use Spanish to communicate emotionally meaningful content. Without prompting, both of them used two similar examples during their interview. The different phrases used to say “I love you” in Spanish (“Te quiero,” “Te amo,” “Te adoro,” for example), in their experience, hold nuances that are missing in the English language, and therefore more accurately communicate their emotional and interpersonal experiences. Additionally, they employed examples involving the experience of anger and rage. For Alba, expressing herself in Spanish feels closer to her experience of rage than if she were to label her emotion in English:

“I think Spanish is my emotional language in the sense that there are certain experiences that won't feel the same without knowing about them in Spanish. When I'm really angry, to be able to say “rabia [rage]” like anger and to be able to roll the “r,” to really allow the affect to come to the surface... [In English,] I won't really process that experience emotionally. I think intellectually I live in English but I... I think emotionally a lot of my experiences do get expressed in Spanish.”

Quality of interpersonal experiences of intimacy in Spanish.

Participants reported feeling more connected to people when they speak in Spanish. Antonella, Cristina, and Pablo used the words “intimate” and “warm” to describe the Spanish language and their experiences using it. Antonella expanded her description by using the terms “comfort” and “hold me” to further depict her experience in Spanish:

“There's more emotion in the Spanish language. There's more warmth in the Spanish language. There's like a "hold me" kind of feeling for me. There's a comfort...When I hear people speaking in Spanish, it feels comfy.”

Lucía, Antonella, and Sofía illustrated their points with examples from their personal lives. When asked if there were any words they missed in Spanish when speaking in English, they explained that they mostly missed the option of communicating in Spanish in personal settings, but did not have specific words in mind.

Lucía: “With my children or with my husband...I want to say something that feels more... close. And, you know, I maybe say it in Spanish. Unfortunately, my kids aren't fluent [in Spanish.]”

Antonella explained that she misses the opportunity to express herself in Spanish with English-speakers only in personal settings, where communication might call for a higher level of intimacy in comparison to professional settings:

“I want to be able to use phrases [in Spanish] because... There's intimacy. In an intimate space...I want to be able to bring those things up. Where, generally speaking, at school and at work, I don't necessarily see those places as a place to expect those things, so I don't miss them.”

Sofía also feels differently when expressing herself in Spanish versus in English with her son:

“With my son... perhaps [is] where I feel the most difference. There is a stronger...a more emotional connection. The affective connection is different with him when I'm speaking Spanish than when I'm speaking in English.”

Alba used an example from one of her clients that resonated with her experience:

“I just started seeing someone who is fluent in both languages. He said, "when I talk about my family in English it feels like they're outside of the home. If I talk about them in Spanish it feels like they're inside of the home.”

Referring to the emotional connection that Spanish can instill in a relationship, Sofía noted that many of her second-generation Hispanic clients use English in family therapy, and in their personal lives, to individuate from their parents. Additionally, more concretely, the language creates a linguistic divide that also helps with the individuation process when parents do not share the level of fluency as their children.

Hypothesized factors impacting experiences in Spanish.

Participants also theorized about the possible mechanisms behind the patterns outlined above. Isabella connected the closeness she experiences to her emotions in Spanish to Spanish being her native language:

“I think that in a social situation...Let's say I'm angry. I'm pissed off. Then I go off in Spanish. When you're angry, you go to your primary source of... Which would be the Spanish... But, of course, I can say the nice words in English too.”

Though Isabella is able to express herself clearly and easily in English, her emotional expression of anger feels closer to her emotional experience, according to her, in Spanish, her native language.

Lucía and Sofía hypothesized that the experiences they have had in Spanish and the people with whom they regularly speak in Spanish could make the language feel more intimate and create a stronger emotional connection between them and the person with whom they speak in Spanish.

For Sofía, the closer or different emotional connection she feels with her son in Spanish could be connected to the childhood experiences, memories, and emotions she encoded in Spanish. These memories are being evoked during the interactions with her son when she speaks in Spanish:

“For instance, if I'm singing a song that reminds me of my childhood. That's connected to my childhood, so I guess in that way, it's a stronger emotional connection...And so I feel like that's a bond that I have with him [her son] that's more connected to my childhood. That's not necessarily connected so much here [at work] in childhood because I feel like my identity here [at work] is much more connected to my adult life.”

For Lucía and David, the stronger emotional connection they feel in Spanish with their clients and family members could be connected to the shared values and cultural experiences. Lucía, who was born and raised in Manhattan by South American immigrant parents, even noted that her family of origin prioritizes connectivity and closeness, a value that she could be experiencing and conveying when speaking in Spanish. David implied that the cultural similarities between him and his clients could be behind his increased level of comfort and familiarity when practicing psychotherapy in Spanish:

“You know, I'm not sure if it's the language or also the people that I've seen. The clients that I've seen in Spanish here. They're Hispanic. It's also the cultural and personality...I don't know if it's the language only. I don't know if it's some specific trait of the culture... It's the culture that I grew up in... The nuances and even the non-verbal cues...there's a familiarity with it or a way of being able to be natural with that.”

Pablo added that his sense of intimacy may partly stem from the minority status that Spanish-speakers hold in the U.S.:

“There is a sense of warmth about being able to say something in Spanish when it is completely appropriate. There are patients who prefer to speak Spanish even if they are bilingual. And there is an intimacy that is different than the intimacy that may be created [in English] ...There's almost like an instant intimacy. It's almost like if someone is

eavesdropping, an English-speaking person in the clinic, it's kind of like, (whispering) "They can't understand what we're saying. This is between you and I." It feels kind of like intimate... Complicit, private, slightly complicit."

Pablo explained that he did not experience a similar level of privacy and sense of complicity with his psychotherapist in his home country. For him, providing psychotherapy to monolingual Spanish-speaking clients in an English-speaking country crafts a secluded and intimate space where the clients not only feel grateful for being able to communicate in their native language and for being understood in that language, but also for being part of an interaction from where monolingual English speakers are kept out.

Self- and other experiences in English.

This theme outlines the patterns of self-experience and experiences with others that participants described having in English. The experiences described by participants that fall under this theme will be described through the following two sub-themes: feelings of competence, professionalism, and formality in English, and participants' hypothesized factors impacting these experiences (emotional experiences in a second language and the experiential differences related to one's language of training when different from the language of practice).

Competence, professionalism, and formality in English.

In most interviews, when participants spoke of the English language and practicing psychotherapy in English, they emphasized notions of professional competence. Five participants, Alba, Lucía, Antonella, Cristina, and David, reported feeling more competent, confident, and professional in English, both socially and professionally, but especially when they practice psychotherapy.

When asked about what comes to her mind when she thinks of the English language, Cristina, a postdoctoral clinical psychologist working towards her licensure, said:

“I’m thinking of things like professionalism, prestige, sounding smart... If I am speaking English, I’m more likely to feel very professional and very accomplished. But also, [I’m more likely] to have those themes in mind as being important.”

Themes of professionalism and prestige are more important to Cristina in English than in Spanish. This observation directly contrasts the subjects that are meaningful to her in Spanish, which include connection and socializing. Cristina also feels competent when she practices psychotherapy in English. When asked how she feels as a therapist in English, Cristina noted she feels:

“Efficient, concise. I feel like I have a lot of power.”

Answering the same question, Antonella replied with a similar sentiment:

“When I’m speaking in English... The word that is coming is “sophisticated.””

David, an advanced doctoral student in clinical psychology who was previously trained in Spanish and obtained his master’s in psychodynamic psychotherapy, explained that he feels more comfortable as a therapist when he speaks in Spanish. His answer to the question of how he feels as a psychotherapist when he practices in English noted different themes. However, he illustrated an experience with a client that resembled the experiences described by Cristina and Antonella. David shared an example about a bilingual client where he had to switch the language of treatment from Spanish to English following a supervisor’s request. The client’s first language was Spanish, and treatment had started in Spanish, but David’s supervisor did not speak Spanish. Although the client was receptive to the request, the switch impacted the therapeutic relationship and possibly the treatment:

“[The language switch] changed the course of the therapy...But I think it made it more formal, a little bit more distant than it was in the first few sessions, maybe. Because we were both speaking in a language that is not our first language, but we knew that we both could speak our first language, but were not using it. When I would greet her [the client] in the waiting room, she would greet me in Spanish and then when we came into the room, she was like, “oh, now I have to speak in English so...” She would speak in English. And when she would leave a [phone] message to change a time or something, she would leave it in Spanish.”

In this example, David noted that the language switch and its implications, more than the language of treatment itself, could have also caused the change in the therapeutic relationship and treatment. During the interview, David exhibited a similar behavior with the interviewer. In the middle of the interview, which was being conducted in English, David asked the interviewer, in Spanish, that the interview be paused for a few minutes at a specific time so he could make a personal call to his father. When the interviewer noted this later in the interview, David explained:

“It felt like I was asking you, like it wasn't a part of the formality.”

For David, the interview, which was being conducted in English, felt more formal; he naturally switched to Spanish to make a request about his personal life.

Hypothesized factors impacting experiences in English.

In the interviews with Lucía and Alba, they both suggested possible reasons for the feelings of professional competence and formality the participants noted. Lucía contrasted her experiences in Spanish with her experiences in English to explain how she feels. She feels more professional when she practices in English because her emotions feel more contained in English. In addition, Lucía connected this experience to the higher level of knowledge and clinical vocabulary she

possesses in English, as compared to Spanish, due to her training and professional experiences. Finally, she also remarked that Spanish feels more familiar because it is her native language:

“[In English,] I feel contained. I have more words in English in therapy. I feel more competent. I keep thinking the word professional, but that's not really accurate... There's something about that or the connotation really is that I fit... certain boundaries... And while it's the same in Spanish there's something about speaking in Spanish... it feels more because it's my mother tongue that it feels more familiar, less professional somehow.”

Alba, a third-year doctoral student in clinical psychology whose training and supervision is mostly conducted in English, expressed she feels more confident and knowledgeable in English. Like Lucía, Alba hypothesized that this difference is likely connected to the language of her education:

“I think that this is what leads to my continued development of knowledge and acquisition of language in English... And those very same things get... stuck in Spanish because I don't stimulate them... The lack of confidence [when I practice in Spanish] stems from a lack of [clinical] knowledge [or] from a very narrow knowledge base. I don't have a wide [clinical] knowledge base in Spanish.”

Cristina also agreed with Alba and Lucía's hypothesis behind this experiential difference when practicing psychotherapy in Spanish and English. This hypothesis connects to the following theme, Language Choice in Training and Supervision, where participants who had been supervised in Spanish expressed gratitude for that experience, noting that supervision and training in the language of treatment was very helpful in developing clinical skills in Spanish and strengthening their confidence.

Language choice in training and supervision.

This theme explores the different languages used in supervision of clinical cases during the participants' training years, and illustrates the impacts experienced by participants on their clinical abilities and psychotherapeutic practices.

All nine participants reported having very few supervisory experiences in Spanish during their graduate training to become mental health professionals in the U.S. Five participants with different degrees (in clinical psychology and social work)—Miguel, Cristina, Pablo, David, and Isabella—conveyed that their supervision was mostly in English, despite treating clients in Spanish and having Spanish-speaking supervisors. David received supervision in Spanish during his terminal master's degree in his country of origin, but has not yet received supervision in Spanish during his doctoral training. David even shared an example where the language of treatment had to be switched to English, the language of supervision, due to the supervisor's language limitations and the limitations in finding a Spanish-speaking supervisor to supervise the case (see pages 50-51).

Cristina summarized her training and supervision experiences by noting the irony in the contrast between the content discussed and the language used to discuss it:

“I had supervision for my Spanish[-speaking] people, but we actually barely speak Spanish in those settings. We talk about culture and cultural differences and the impact of the language, but we don't actually use the language itself most of the time...It's actually always been interesting to me that we automatically talk about clinical situations in English.”

As Cristina suggested, these supervisors were able to speak Spanish fluently but defaulted to conducting supervision and discussing clinical material in English. Cristina, Miguel, Pablo, and

Isabella also noted that their supervisors for Spanish-speaking cases used Spanish in supervision only when quoting a client or referring to a culture-bound experience that was likely to lose meaning and nuance if translated. Miguel, Pablo, and Isabella, the three licensed social workers, reported that their training, supervision, and team meetings involving the discussion of Spanish-speaking treatment cases have been in English, even when most supervisors and clinicians involved in the team meetings were Spanish-speakers providing mental health services in Spanish as well. Isabella connected this trend to the fact that her training occurred in U.S. “American schools” and in settings within English-speaking systems.

Alba, Lucía, and Antonella reported having had one or two experiences of supervision in Spanish. Alba remarked that she had to ask to get a Spanish-speaking psychologist to supervise a Spanish therapy case, and that she was assigned to one once she asked. Antonella spoke of having a similar experience to the one described by Cristina, where the supervision experiences for therapy cases conducted in Spanish were often conducted in English despite the supervisor’s Spanish fluency:

“[Before] internship [year], all but one of my supervisors were bilingual. But all of that supervision was done in English. Talking about the patient was in English, unless we got to what a specific intervention would be. I would like to talk about my patient in English and then...there would be Spanish if I said, "Okay, I'm going to say this to the patient"..."

In contrast to the supervisory experiences of the aforementioned eight participants, Sofia stated she had numerous supervisory experiences that were conducted in Spanish:

“I was very fortunate to have several Latino supervisors who were also not born in the U.S. and spoke Spanish well. [In supervision], I would speak in Spanish and I was able to talk about my work...to use my patient's words and not have to [translate] them.”

Impact of language choice in training and supervision on practice.

Participants stressed the impact that language choice in supervision has had on their training and practice. All participants who indicated that they have received supervision in Spanish stressed the importance of this practice. Alba explained that she was choosing to remain in a supervisory relationship which she described as interpersonally difficult in order to be supervised in Spanish, the language of treatment. With a tone of admiration and excitement, she illustrated her experience of being supervised in Spanish and hearing clinical terms and theorists in the language of treatment for the first time:

“I can manage to stay [in supervision] because I know that I have a lot to learn from [him], even the names of the therapists, the theorists, he'll say them in Spanish. Instead of saying Yalom, he'll say “Jolom,” and I'm like, "ah, write that down." So, he really has the capacity to switch to the Spanish all the content and the words and the techniques...I'm just like, “oh my god.””

Antonella described her thought process and reactions to receiving supervision in English:

“I was not super confident in my clinical skills in general...I was like, “I'm not learning [to do therapy in Spanish from my supervision in English]. I don't know how to say, “bipolar disorder” in Spanish...” I didn't have the language. I learned Spanish at home...I didn't formally learn it. So, I didn't know how to say those [clinical] things... I wanted to be able to think about patients in Spanish...”

Antonella then contrasted that experience to her experience of being supervised in Spanish for the first time, commenting on the difficulties and benefits of the experience:

“[The supervisor] would make us talk about patients in Spanish which makes sense. She wanted us to conceptualize the patient in Spanish... Training our brains to think in Spanish

to be in touch with the patient that way, not just translating. A translation, that's not therapy, that's translation. I think that was her point, which I agree with... If I'm talking to a patient [in Spanish] and they're saying something, in my mind I'll think in English like, "oh, ask about protective factors." It creates a distance... I realized this supervisor, what she was doing was helping us break down that distance. It was very intimidating... I think back then it just felt like, "I don't know. This is hard..." But I think I was very grateful for it later on. Once I had more confidence, I realized, "oh, I wish I had more of that..."

Antonella's account of her training experience stresses the importance of overcoming the fear of and anxiety around speaking Spanish in supervision. She described how she was able to benefit from expanding her clinical vocabulary in Spanish. Moreover, for Antonella, thinking and conceptualizing the client in the language of treatment reduced the perceived emotional distance created by the cognitive effort of translating concepts and interventions discussed in English in supervision.

Sofía, the one participant with several supervisory experiences conducted in Spanish, also stated that receiving supervision in Spanish improved her clinical vocabulary in that language. Additionally, Sofía commented on the interpersonal components of these experiences. According to Sofía's account, having a Spanish-speaking supervisor supported her development as a clinician and enhanced the identification she experienced with her supervisors due to the shared culture and language:

"I think it was then when I started to pay attention to things like when do I or the supervisor switch to English when we're speaking Spanish, the meaning of words in different countries. One word can have a different meaning in different countries... And then I think in terms of transference and countertransference, there was an idealization of some of these

supervisors because they represented what I wanted to be, what I was working towards becoming. In terms of my own issues of authority and things like that... were also much more present in the room. They [the Spanish-speaking supervisors] represented a maternal or paternal figure. And so being also aware of those kinds of emotional experiences that were being triggered by working with these supervisors.”

Of the participants who had not been supervised in Spanish, Cristina explicitly outlined the drawbacks of receiving supervision in English for the clients she was treating in Spanish. She drew from her training experiences in English and how the language in supervision has fostered the growth of different aspects of her clinical work. Cristina first elaborated on her experiences with role playing and other modeling techniques in supervision:

“Even when we've done role plays, when mentors are like, "Well what would you say? This is what I would say." You have examples in your mind of ways to phrase things and deliver information. I can do that very quickly in English. With the exception of being in a group, I've never seen an individual session of therapy in Spanish... even though I do it all the time. That's how I learn...I hear my mentors talk...And I've never really heard...somebody talk clinically to their patients in Spanish. And I think a [therapy] group is [different] because so much of the work is being done by the group members. And you're there to redirect attention, emphasize a particular phrase that was used, maybe every once in a while, interpret, but... There's way less pressure to respond to everything and to get it just right...In individual [therapy], there's more of an understanding of, “I am here to offer someone something that they can't quite do on their own otherwise they wouldn't be in therapy.” And I think in that offering, I've never heard the phrasing of the things I'd like to

communicate to a patient [in Spanish]. I've never heard people say those things and put that stuff together in [Spanish] phrases that are really concise.”

Cristina also described how the lack of these teaching experiences in Spanish has impacted her work and ability to communicate clinically with other mental health providers. She said she resorts to descriptive explanations in Spanish of clinical terms in English, using colloquial words in a roundabout way to describe what she could say more succinctly in English:

“I don't even really know how...how to actually have all the words in Spanish to describe clinical experience in the way that I've been taught [in English] ...But just even the language...the way we're used to talking about clients. I can be very descriptive in Spanish ...but I don't think that feels so clinical to people. And then simply, a lot of words don't exist. There's no direct translation for really important [terms]. How are you going to talk about a case without being able to use [them]?”

Additionally, Cristina noted that the lack of supervision in Spanish also makes it more difficult for her to provide interventions in Spanish that feel effective:

“[I] have never been trained in Spanish. [I] don't have a lot of experience hearing therapy in Spanish. It's a lot of effort. Then having to take the conceptual interpretation and then translate that...It doesn't feel so natural anymore... I have to offer them something clinically useful. And it's already hard enough to do that in English.”

Miguel, Pablo, and Isabella, the three licensed social workers interviewed, did not discuss their reactions to their lack of supervision conducted in Spanish. The six other participants, directly and/or indirectly, emphasized the benefits of receiving supervision in Spanish for treatments conducted in Spanish. They discussed how this experience enhances their clinical vocabulary, improves their confidence and sense of professionalism as clinicians, expands their repertoire of

interventions, and likely reduces the felt emotional distance from the client in the therapy room by removing the need for internal translation while conducting therapy. Additionally, the shared linguistic and cultural experiences for one participant, Sofía, strengthened the supervisory relationship and enhanced her professional development by providing her with a role model with whom she identified. For another participant, David, the language difference between the supervisor and the client resulted in having to change the language of treatment and contributed to a change in the interpersonal experience between the clinician and the client.

Possible impact of language-related differences on psychotherapy.

This last theme highlights the differences that participants have noted in their psychotherapy styles based on the language they use in treatment and how these differences could be impacting the treatments they provide.

Participants reported the possible impacts of language-related differences on their psychological practice, including their varying comfort with religion, the assumptions they make about clients based on the language spoken with them, and five main differences in their intervention choice and delivery. Participants expressed they vary their interventions in how much they challenge their clients, and their use of interpretation or relational interventions, psychoeducation, counseling strategies, and collaboration.

Participants were asked about the differences in interventions and therapeutic style they noticed when providing psychotherapy in English versus in Spanish. David and Isabella indicated that their clinical interventions vary based on the client, not on the language they speak in treatment. In contrast, the seven other participants reported experiencing some overarching differences between languages. Six of these participants described specific differences they have

observed in their own practice. For example, Alba shared that she feels more comfortable with clients' blessings in Spanish:

“I noticed when I was doing my very first neuropsychological testing for a little kid that when I talked to the mom, [who] was very religious... I realized that in Spanish I do say a lot more “Si Dios quiere” [God willing] than in English. I never say, “God willing” [in English]. But I do say [it] a lot in Spanish and I mean it... Whenever we would set up an appointment... I would say, “So I'll see you tomorrow at 5” and she would be like, “Okay Dios mediante” or “Si Dios quiere” [both meaning God willing] and... I wouldn't know how to... respond to that. I started to notice that she was speaking to that part of me that also uses God in Spanish... But there was some chord that was struck... One of the interviews with her, she said that she had taken the kid to the doctor and found something right in time and I said, “Gracias a Dios usted hizo eso a tiempo” [Thank God you did that on time] and I was like “Oh no, I used “God” in here!... She's religious so it's fine with her. But what if I had done that with someone who is Spanish-speaking... And wasn't religious... And I let that side come out so... it like sent me into this whole thing about like how much am I disclosing...?”

Alba compared this example to one with a monolingual English-speaking client. Alba's English-speaking client, like Alba and her monolingual Spanish-speaking client above, was a practicing Christian. Alba reported that she was less likely to reciprocate the use of religious terms before, during, and after sessions with this client than with her Spanish-speaking client. Alba also added that this difference could likely be related not only or not necessarily to the language in treatment but also to the appropriateness of the clients' behaviors in treatment. Alba explained that her

English-speaking client's religious commentary was in part a symptom of her anxiety and obsessive-compulsive tendencies.

Lucía and Miguel suggested that they make assumptions about their clients' experiences based on the perceived shared cultural values with their Spanish-speaking clients. When Lucía was asked about the reactions she experienced with Spanish-speaking clients, she expressed:

“I think my countertransference then was more of like: “I get it. I understand this, and I don't need to explore it more...Just culturally, it makes sense for me not to explore more,” when in fact, “No, it's actually quite important for me to explore more regardless.””

As Lucía explained, she used to ask fewer questions regarding the experiences reported by her Spanish-speaking clients, assuming she understood their experiences based on the shared cultural experience as Hispanic individuals living in the U.S. In contrast, Lucía indicated that she now recognizes the importance of detailed inquiry even with individuals who seemingly share her cultural values.

Miguel reported having a similar reaction to his monolingual Spanish-speaking clients:

“When...If a Spanish [-speaking patient] is talking, for some reason I right away go, “I understand. I know what you're saying. I've experienced that. I know what that means.””

In discussions of the differences she experiences when practicing psychotherapy in English versus in Spanish, Lucía included the concept of authority in the psychotherapeutic relationship. She reported that the sense of hierarchy she experienced with her older family members was evoked by her use of Spanish with older, monolingual Spanish-speaking clients. In those therapeutic relationships, she used to believe that challenging and questioning clients was culturally inappropriate:

“I had a much easier time and it was much more expected of me with my English-speaking clients to press, and to explore. What I understood was that they were expecting that of me whereas with Spanish speakers, I intuited that they weren't expecting that of me as much. The Latin culture has these hierarchies... or at least historically have been more paternalistic, very much about being respectful to your elders... Something that I have taken very well...in my own family. So, it was harder for me to be the person in the room that was being looked at as the professional and...ask questions that would not have been in my own mind acceptable to ask...They would've seemed disrespectful... How do I assume this professional role with these older Latin individuals that [are] normally...they're hierarchical? But that certainly was not how I felt with my English-speaking clients.”

Lucía's tendency to explore the experiences of her English-speaking clients more seems related to two notions: to the assumptions she made about the experiences of her monolingual Spanish-speaking clients due to their shared cultural experiences and to the hierarchical structure she experienced in the psychotherapy room with Spanish-speaking clients who were older than her.

Miguel and Pablo observed they were more likely to use “psycho-education” and “pure counseling” or more supportive psychotherapy, respectively, with their monolingual Spanish-speaking clients. Their clients' educational background seemed to influence this choice. Most of their monolingual Spanish-speaking clients come from the same community and neighborhood, and often include individuals who emigrated to the U.S. from their country of origin due to poverty, in search for greater financial opportunities. Many of these clients did not complete secondary studies. In contrast, their monolingual English-speaking clients are more likely to have graduated high school or obtained a General Education Diploma (GED). Following these differences in educational levels, Miguel explained:

“They're [monolingual Spanish- and monolingual English-speaking clients] really different in terms of educating and explaining...The English[-speaking] population that I've worked with, many times they have a good understanding of what's going on. I'll give you an example: depression...I find with the Spanish[-speaking] population, they have a hard time...explaining what the symptoms are...I'll say, "tell me a little bit about the depression. How does that feel for you?" And they'll go, "oh, it hurts here." They start up with physical. And then, you kind of guide them into the emotional part of the depression. And then it's a little about educating or "This is what happens. These are the symptoms..." And I think education also plays a big role. You have a high population here of Spanish[-speaking] patients who don't have a high level of education, not all of them. So, in terms of expression, it's not something they're used to. They're used to going to the doctor's and saying, "my stomach hurts..." The people who are here [and] speak English and have been educated... their ability to express themselves is at a higher level. They have an understanding.”

Pablo expressed that he noted a similar difference, also connecting the difference in his intervention choices to his clients' educational standing rather than directly to the language of treatment:

“They [Spanish-speaking clients] have very low levels of education. And with them, is never psychotherapy. Is just pure counseling. Is just helping them to resolve the everyday things about life. You know, it's much more basic.”

Another important difference that two participants observed in their therapeutic style and intervention choice between treatments conducted in English versus in Spanish related to their proficiency of mental health terms in Spanish. Cristina and Sofía both used the term

“collaborative” to describe the experience of providing psychotherapy in Spanish. Cristina started by portraying how she feels when she practices psychotherapy in Spanish:

“Like a work in progress. In English, I can be more certain when I've made an interpretation, for example, or offered a particular skill. I can use a lot less words to communicate a point... I don't know if it's because of Spanish itself, my sort of clinical fluency with the Spanish language in a clinical setting. I feel like it's [working in Spanish] all more descriptive, like we're basically just trying to describe and observe scenes... It feels more collaborative. But not always in a good way. It actually feels like it necessitates collaboration because I have less tools to make something very short, concise and to the point. It necessitates a back and forth to figure out and to make sure.”

Although Sofia's depiction was comparable to Cristina's, her experience of the collaboration with her monolingual Spanish-speaking clients did not have a negative valence. Additionally, similar to Cristina's description, Sofia noticed that she defaults to explaining the concept or technical term that she knows in English for which she lacks the precise word in Spanish, a tactic that leads to collaborating with the client:

“And saying, like “oh... I don't know how to...how this would be said but this is what I think it would mean” and explaining more the concept. I think I certainly still have moments like that when I'm doing therapy in Spanish. I'll say it [the term] in English. And then I'll say, "I'm looking for, you know, the word for this." And sometimes the patient will help me out.”

Cristina and Antonella also referred to employing interpersonal interventions and focusing more explicitly on the therapeutic relationship with their monolingual Spanish-speaking clients. Cristina stated:

“[With] my Spanish-speaking clients that are coming in for Axis I disorders, I'm much more likely to be interpersonal in my delivery of interventions and less apprehensive about using the relationship...pretty early in the treatment. And talking about it openly as opposed to me just keeping it in my mind...I'm way more likely to accept a present. I would interpret it but can also just accept the present. Because I'm also assuming I might get multiple ones and I can't interpret all of them. Well, I guess I could interpret all of them, but it would get a little... No one would like that... within boundaries, of course. It still just feels more, familiar, familial, personal. There are different markers of authority. Like, my Spanish-speaking clients, I think, reinforce their own understanding of boundaries by alluding to things like my education or degree. But still giving presents as if I'm their granddaughter, right. Or like kissing me on the cheek...My English-speaking clients...I'm sure this is not the case, but at least with what they share openly... Some of them could care less about my education. They have their assumptions, like, "you're here. That's enough. That means that you're this.”

Cristina is less likely to pathologize the behavior of gift-giving in her Spanish-speaking clients; she categorizes it as culturally-appropriate. Cristina also alluded to other behaviors that she might classify in a similar manner, like kissing the therapist on the cheek and other clients' interpersonal actions focused on enhancing the relationship. Cristina then explained how her perception of her monolingual English-speaking clients influences the interventions she is more likely to use with them, and how they differ from the ones she uses with her monolingual Spanish-speaking clients:

“I guess there's something about English-speaking clients that...in some ways feels more threatening? I think I use a lot more...interpretation actually...I think they take me more

seriously when I can sort of prove to them that I can outsmart them... I feel I can push. I feel like my buttons are pushed in different ways with English-speaking clients... So, it automatically feels more distanced right? Like I have to prove myself in some way. Like I sort of have to figure the game out.”

Cristina reported that she tends to use interpretation and challenging techniques to gain the trust of her monolingual English-speaking clients. In contrast, she expects her monolingual Spanish-speaking clients to trust her through their relationship, and then feel more comfortable with intellectual interventions like interpretation. The interventions Cristina uses with her monolingual Spanish-speaking clients are more relational in nature:

“With Spanish-speaking clients, it's sort of the opposite. I'm trying to get them to think symbolically about and interpret it and it's not that they can't but how you build trust first is very different. If I can tolerate the familiarity, the familial space and be supportive and not hold them accountable psychologically for every little thing and give them some breathing room to settle in, they are much more likely to let me interpret later... There can be games to all of this, like unconsciously. But it does feel like the first step is to learn what it's like to be in a room together.”

Antonella also observed that she is more likely to focus on the therapeutic relationship when working in Spanish. She explained that the concept of “confianza” or “trust” and “warmth” permeate therapeutic encounters with monolingual Spanish-speaking clients, and that her monolingual English-speaking clients emphasize more technical issues of psychotherapy.

“I don't know if it's “confianza” or warmth... One of my [monolingual Spanish-speaking] patients recently... in talking about like how treatment has helped her... “You're like my friend.” This is not someone that doesn't have good boundaries. She doesn't actually think

I'm her friend...where with the English-speaking patients, generally speaking, I don't think they have the same expectation... It's been more about like, "Are you going to keep confidentiality?" and, "are you going to be effective?"

CHAPTER V: Discussion

Interview Themes

Language-related identity differences and integration.

The results summarized under this theme replicate results from similar qualitative studies (Alonzo, 2007; Sprowls & Biever, 2002). In this study, all nine participants identified differences in their felt experience both in a social environment, and professionally when practicing psychotherapy in Spanish and English. Some participants noted they continued to experience these differences prominently at the time of the interview, while others suggested that time and practice had led to an integration of these identity differences. Participants in the Alonzo (2007) and Sprowls and Biever (2002) qualitative studies also described experiencing identity differences in Spanish and English. Some psychotherapists “described a sense that they were in fact two different people when they conducted therapy in another language,” referring to their mannerisms, world views, perceived censorship, and sense of time depending on the language spoken (Sprowls & Biever, 2002, p. 109).

Sprowls and Biever tie the differences in language-related self-experiences to psychotherapists’ cultural upbringings. They suggest that cultural principles of relating are evoked by the language being spoken by the psychotherapists. All participants in this study identified as bicultural. They had strong attachments to both their U.S. American and Latinx cultural roots. As Valdez (2000) stated, bicultural individuals learn principles of behavior associated with both of their cultures, adapting to “function and succeed in two cultural environments” (p. 240). Verdinelli and Biever (2009), agreeing with this notion, argue that living in two cultural worlds likely leads to the development of two separate systems of values and skills that support these possibly separate cultural lifestyles. Moreover, participants in a study of linguistically diverse bilingual and

multilingual psychotherapists (Rosenblum, 2011) reported they felt as if they were “being brought back to family ties” when they spoke their native language (p. 50). The cultural or family frameworks in which the participants grew up, each associated with one language and evoked when that language is spoken, could relate to the different self-experiences the participants endorsed in Spanish and English.

Clauss (1998) also connected the stylistic shifts she noticed in herself to specific cultural phenomena stored in Spanish and English. For example, she indicated that she was more likely to joke around and be more animated with her clients when practicing psychotherapy in Spanish. According to Clauss, these behavioral differences could be related to the term “bromear” (joking around) and phrase “con más ánimo” (more animated) that were often used in Venezuela, the country where she learned Spanish.

These cultural notions of behavior could also help explain the interactions between language-related identities reported in this study. Alba conveyed that she experiences an emotional struggle when attempting to apply philosophies she learned in English that now feel like a part of her overall identity, such as feminism, to the culture she associates with her home country. She felt as if she was using a U.S. American lens to understand behavioral patterns in her country of origin, despite the widespread applicability and importance that feminism holds for her. In Sprowls and Biever’s 2002 study, some participants described an interaction between their identities similar to the one Alba reported in this study. Lilia, one of the participants in that study, explained that she had become more westernized after having lived in the U.S. for a few years. She believed it would be difficult to use the expectations around boundaries she had developed in the U.S. if she were to return to her home country in Latin America to practice psychotherapy. Referring to a book by De Courtivron (2003), Espín (2013) connects learning a second language to the

immigration and acculturation process, remarking on the impact that these experiences have on the person's identity development. One learns to "live" in a new language and, in turn, "becomes immersed in the power relations of the specific culture that speaks the specific language" (Espín, 2013, p. 13). Alba feels discomfort in applying these power relations from the U.S. to understand the machismo culture, which holds different power relations, in her country of origin.

While all nine participants in this study identified differences in their language-related identities to some degree, three participants—Lucía, Isabella, and Sofía—reported experiencing a reduction of these differences, or an integration of their language-related identities, over time. They stressed that their level of comfort and therapeutic style was similar in English and Spanish. Some participants in the Sprowls and Biever study also explained that they felt equally comfortable and equally "themselves" in both languages at the time they were interviewed. Patricia, a participant in that study, stated that when she first began working in Spanish at a younger age, she experienced a difference in herself when she spoke Spanish and English. However, Patricia said, "I've integrated so that when I move between languages or between cultures, then I really can be myself in a way that's very genuine and very real" (2002, p. 81).

Lucía, Isabella, and Sofía referred to time and increased experience in practicing psychotherapy in both languages as the two main factors that facilitated the integration of their language-related identities. Hoffman (1989) and Espín (2013) suggest that therapy can become a "tool supporting psychic integration" for clients who immigrated to another country and speak two languages (Espín, 2013, p. 23). This study did not pursue the topic of language choice in the participants' own psychotherapy in detail, which would have been a helpful addition to this part of the discussion and understanding the results around psychic integration for psychotherapists. Some participants suggested that conducting therapy and living in both languages has supported

psychic integration for the psychotherapist, but further studies are needed in this area to support this claim.

Self- and other experiences in Spanish.

Participants used words like “warm,” “comfy,” and “effervescent” to describe what came to their mind when they thought of the Spanish language. Similarly, they used the terms “less removed,” “visceral,” and more “intimate” to describe their emotional experience with others when speaking in Spanish. The increased emotional connection experienced intrapsychically and interpersonally by participants when speaking Spanish can be understood by reviewing four main groups of research: the learning environment of the language spoken, the importance of one’s native language for the retrieval of emotional and episodic memory, the connection between language and culture, and the shared cultural values between the client and psychotherapist.

Marcos (1988) noted that oftentimes, as was the case for most of the participants in this study, Spanish is the language involved in the social environments of family, community, and friends. Castaño, Biever, González, and Anderson (2007) add that “bilingual clients who acquired Spanish in home and social contexts are likely to feel more comfortable using Spanish when discussing emotional or relationship issues” (p. 670). This observation may partially explain participants’ tendency to focus on the therapeutic relationship and to use more relational interventions during treatments conducted in Spanish.

The choice of language in interpersonal interactions, including psychotherapy, has been shown to impact the emotional experiences of the individuals involved (Altarriba & Santiago-Rivera, 1994; Gutfreund, 1990; Marcos, 1976), a finding that was corroborated by the results in this study. In this study, both Alba and Isabella reported turning to Spanish, their native language, to express strong emotional reactions, like their experience of rage. Similarly, Sprowls and Biever

(2002) noted that several of the participants in their study reverted to their first language when aiming to convey something with deep emotional meaning, and used anger as an example. Altarriba (2003) theorizes that bilinguals may represent emotion words differently in their two languages. Similarly, Javier, Barroso, and Muñoz (1993) suggest that “the communication of memories of personal events is qualitatively different in the two languages” (p. 334). Espín (2013) pointed to the research of Polish-Australian linguist Anna Wierzbicka, who asserts that the feelings one describes in seemingly equivalent words in different languages (i.e. “rabia” and “rage”) likely differ in emotional experience and content due to the different cultural contexts of the words (2013). Alba made a similar statement during her interview, reporting that she felt a difference in the experience and expression of anger in each language.

Participants in the Sprowls and Biever (2002) qualitative study observed they were more likely to use small talk, resort to a more personal use of themselves in therapy, and perceived themselves as being viewed as extended family members by clients in treatments conducted in Spanish. These experiences pertain to cultural patterns associated with Latin America. As mentioned earlier, Clauss (1988) connected her stylistic shifts in Spanish and English to the cultural meaning contained in the two languages. Sprowls and Biever (2002) note that the “principles of relating” within Latin American culture evoked through language likely guide the way psychotherapists interact with their clients working in Spanish (p. 80 and p. 109).

These culturally-based principles of relating expressed themselves in multiple ways for the participants. Some participants reported that they experienced an increased sense of familiarity with all of their monolingual Spanish-speaking clients when conducting treatment in Spanish. Lucía, in contrast, indicated that the level of familiarity she experienced in the therapeutic relationship with monolingual Spanish-speaking clients depended on the clients’ age. According

to Lucía, she experiences a hierarchical relationship with monolingual Spanish-speaking clients who she perceived to be her elders. Lucía connected this pattern to the hierarchical nature of relationships in her family of origin. Two participants in the Sprowls and Biever (2002) study explained that they worried about the level of formality and familiarity with Spanish-speaking clients as well.

David suggested that shared values and nonverbal cultural references contributed to the increased comfort he experienced with his monolingual Spanish-speaking clients. Psychotherapists participating in other qualitative studies (Alonzo, 2007; Sprowls & Biever, 2002; Verdinelli & Biever, 2009) have mentioned similar experiences, tying their greater familiarity with Latinx cultures to the comfort they experience with their monolingual Spanish-speaking clients. Sue (1988) posits that cultural match between clients and psychotherapists, such as values, life styles and experiences, can affect the psychotherapeutic experience and psychotherapy outcomes. The shared cultural referents that the participants experienced with their monolingual Spanish-speaking clients could have impacted their relationship, increasing the psychotherapist's sense of affinity.

Pablo also reported experiencing an increased sense of intimacy with his clients when he spoke in Spanish. In contrast to David's theory, Pablo emphasized the minority status Spanish-speakers have in the U.S. as a possible explanation for his experience. The members of the psychotherapeutic dyad may experience a sense of solidarity based on the shared experiences as a result of their minority status. The reviewed research underlining the strong connection a person can have to their childhood through their native language sheds further light on Pablo's idea. The client and clinician could both find their home when speaking their native language, an experience that feels especially intimate for two immigrants in a foreign country with a different language and

set of customs. Espín (2013) said learning the official language of a new country involves learning one's place in the structures of the new society. Being able to speak one's native language, either as clinician or client, can evoke feelings of freedom from those structures, reverting back to the possibly more comfortable and natural ones associated with one's home culture.

Self- and other experiences in English.

Participants used words like “contained,” “distant,” “professional,” “accomplished,” “efficient,” and “concise” to describe their interpersonal experiences in English. The literature refers to an individual's second language as a barrier to fully experiencing emotions, especially the emotions associated with memories encoded in the individual's native language. The experience of feeling “contained” and “distant” could therefore be associated to the fact that English was the second language of many participants.

Participants may have also felt more emotionally distant from their clients in English due to cultural norms they associate with U.S. American culture. Clauss (1998) brings attention to the dynamics of boundaries and roles in Latin American countries and the U.S. While Latin American clients may at times experience professionals as an extension of their family (Clauss, 1988; Sprowls & Biever, 2002), the professional boundary appears less fluid in mainstream U.S. culture. The cultural norms that participants associated with their U.S. American identity, evoked through their use of the English language, could make them feel more formal, and therefore more distant from their clients.

The second group of descriptors used by participants to illustrate their self- and other experiences in English revolved around competence and professionalism. These results replicate results from other studies. Participants in the Sprowls and Biever (2002) and Alonzo (2007) studies also suggested they lacked confidence in the services they provided in Spanish. The participants

in this study explained that feeling more “professional” and “efficient” in English is partly related to their language of training. Eight of the nine participants received all of their graduate school training in English. Castaño et al. (2007) posit that the language of training impacts the psychotherapist’s experience in providing therapy, first in terms of their competence:

“Bilingual psychologists who receive professional training in the United States are trained in English, regardless of their proficiency in other languages. As a result, they learn therapeutic techniques and terminology in English. Proficiency is context dependent, which makes it difficult for English-trained bilingual psychologists to translate the concepts and therapeutic process into the contexts of working with clients using a language other than English” (p. 668).

Participants’ feelings of competence in English may be informed in part by their awareness of ways in which they feel deskilled when working in Spanish. Spanish, in theory, is participants’ second language for psychotherapeutic concepts and terms, as Castaño et al. also underscore in the quote above. Eight participants learned most, if not all, clinical concepts and vocabulary in English. The concepts they use and skills they implement in psychotherapy, as well as their psychotherapeutic identities developed through their training, are encoded in English. As Walsh warns, “we cannot assume that...development in one language-self is automatically transferred and generalized to other language-selves” (2014, p. 68). A difference in language proficiency for bilingual psychotherapists can lead to the experience of foreign language anxiety. Trepal, Ivers, and Lopez (2014) studied foreign language anxiety in six mental health counseling students through a qualitative, phenomenological approach. They defined foreign language anxiety as a “feeling of tension and apprehension specifically associated with second language contexts, including speaking, listening, and learning” (MacIntyre & Gardner, 1994, p. 284). The results from

the study emphasize a pattern between the participants' language anxiety and their perceived self-efficacy: the more anxious they felt providing mental health services in a second language, the less confident they felt about their performance.

In this study, Antonella talked about her experiences providing psychotherapy in Spanish after being trained to conceptualize and deliver interventions in English. She explained she often mentally translates her training during sessions, as she looks for interventions from her repertoire in English and then delivers them to her clients in Spanish. Participants in the Trepal et al. study add that their tendency to focus on pronunciation and translation during a psychotherapy session exacerbates their language anxiety. Eight of the participants in this study were not trained in Spanish so most or all of their clinical vocabulary is in English. The increased "efficiency," sense of "accomplishment," and competence could be experienced in contrast to a type of "second language anxiety" they experience when providing psychotherapy in Spanish.

Participants in the Sprowls and Biever (2002), Castaño et al. (2007), Verdinelli and Biever (2009) reported a similar concern with their language competency, which Sprowls and Biever label as "performance anxiety." This performance anxiety associated with participants' language competence in the language of treatment reportedly made them feel less confident in or masterful of their services in that language. More specifically, Castaño et al. (2007) detailed that "despite their conversational fluency, over half of the [127] participants expressed some level of concern about their use of vocabulary (52%) and applying concepts and theories when working in Spanish (58%). The participants were less concerned about conversational proficiency and grammar, with 42% and 39%, respectively, reporting concerns" (p. 669). The participants reported that, while they feel capable of carrying a fluent conversation in Spanish, they feel more anxious about their clinical vocabulary and ability to express and apply concepts in Spanish.

Participants' language of training also helps explain their feelings of professionalism when conducting therapy in English. Bilingual clinicians' stylistic and experiential shifts "concern the language in which professional development is encoded" (Clauss, 1988, p. 194). Spanish heritage speakers learned Spanish at home and English at school. The early education of native Spanish speakers might have only been in Spanish, but English was the language of their graduate education and training. Spanish-English bilingual psychotherapists may associate the professionalism acquired during training with the English language.

Language choice in training and supervision.

Eight of the nine participants—two doctoral students, three clinical psychologists, and three licensed clinical social workers—reported having few supervisory experiences in Spanish for treatments conducted in Spanish while in training. With the exception of one psychologist, all participants were pursuing or completed their graduate training in two northeast states in the U.S. Sofía, the psychologist who completed her graduate education in a different northeast state in the U.S., had several supervisory experiences conducted in Spanish. Alba, Lucía, and Antonella had one or two experiences of supervision in Spanish. The five remaining participants—Miguel, Cristina, Pablo, David, and Isabella—conveyed that their supervision had been mostly in English, despite treating clients in Spanish and having Spanish-speaking supervisors. David received supervision in Spanish during his terminal master's degree in his country of origin, but had not received supervision in Spanish during his doctoral training years by the time the interview was conducted.

Psychotherapists and psychotherapy students in other studies (Alonzo, 2007; Castaño et al., 2007; Sprowls and Biever, 2002; Verdinelli and Biever, 2009) have also reported a lack of supervision and training in Spanish for treatments conducted in Spanish. Alonzo did not directly

report the language used in supervision for all her 13 participants, but at least four reported having received little to no supervision in Spanish for treatments they conducted in Spanish. Similarly, in the Verdinelli and Biever study, four out of the seven participants who reported providing services in Spanish during their graduate training did not receive supervision conducted in Spanish. And, the three participants who did receive supervision in Spanish only received it for brief periods of time. In a survey of Spanish-speaking mental health providers, Castaño et al. (2007) stated that over half of their 127 participants reported that they had received no training in providing mental health services in Spanish. Highlighting the importance of receiving training in the language of treatment, Castaño et al. noted that most of the polled participants sought training outside of their training program pertinent to their language competency:

“Sixteen percent reported having taken courses in the professional use of Spanish, 39% received supervision of Spanish language services, and 28% had attended workshops or received some other form of training” (p. 669).

The literature underlines several explanations for the mismatch between language used in supervision and language used in treatment. Possible reasons include organizational limitations, level of language comfort of the supervisor, or the unexamined tradition of English as the default language for clinical discussions in many treatment settings.

In this study, the participants who did receive supervision conducted in Spanish for treatments conducted in Spanish expressed gratitude and emphasized the importance of those experiences in their training. Alba reported tolerating a challenging relationship with her supervisor in order to continue her only supervision conducted in Spanish. She found it very valuable and worth the interpersonal distress and disagreements. Antonella reminisced about one particular supervisory experience conducted in Spanish during her interview. She said that being

supervised in Spanish had its challenges and made her feel intimidated, referring to her Spanish language anxiety. Looking back, however, she expressed a wish for more supervisions conducted in Spanish. Sofía, the one participant who had several supervisory experiences in Spanish, delineated numerous benefits. She explained that the relationships with her supervisors developed in Spanish impacted her own identity; it strengthened the identification she experienced with her supervisors, giving her a helpful model to learn from and aspire to. Overall, participants indicated their belief that having supervision in the language of treatment could potentially help both with their competency as clinicians and with their ability to connect with their clients in therapy.

Possible impact of language-related differences on psychotherapy.

Seven of the nine participants in this study suggested that the interventions they use vary depending on the language of treatment. While David and Isabella stated that their interventions were client-specific, the other seven participants noticed some overarching patterns in their style and intervention choices for treatments conducted in Spanish and English.

The first way that language-related differences impact psychotherapy is through psychotherapists' language competence. Clinicians trained only in English are more likely to process clinical information in English, requiring them to translate the material to Spanish before applying it as an intervention, a cognitive burden which may have an effect on emotional availability. Antonella referred to this process during her interview. She explained that it increased the emotional distance between herself and the client during the session because she had to devote additional mental resources to translation.

Castaño et al. (2007) also draw on the literature to point to another way a psychotherapist's language competency can impact the treatment. It can lead to the misinterpretation of clients' explicit verbal communications and/or cultural nuances hidden within them. Cristina and Sofía

described how they collaborated with their clients to bridge their language gap, a similar technique noted by participants in the Sprowls and Biever (2002) study. On the one hand, collaboration to understand each other could be beneficial for the therapeutic relationship, strengthening the connection between psychotherapist and client and engaging the client as an active participant in the treatment. On the other hand, collaboration between clinician and client to understand each other sometimes does not suffice to eliminate the language barrier, and can lead to miscommunication and misunderstandings (Castaño et al., 2007), possibly detracting from psychotherapeutic content and process.

The second way that language-related differences could impact psychotherapy relates the cultural principles of relating that are embedded in each language. Clauss (1988) noticed that her psychotherapeutic work in English required more use of interpretation as a therapeutic intervention. In contrast, she found herself being chattier when working in Spanish. She connected these differences in style to social etiquette:

“This countertransferential reaction indicates that therapy in English suggests a symbolic world and [U.S.] American cultural orientation that is task-oriented and thus provides ready interpretation. In contrast, therapy in Spanish calls up another symbolic world in which the use of chatting represents cultural communication that emphasizes acceptance within the relationship” (p. 194).

The explanation Clauss provides resembles the experience that Cristina described in her interview. Cristina observed that she experienced monolingual English-speaking clients as more threatening than her monolingual Spanish-speaking clients. She therefore turned to interpretation as an intervention to not only help her clients, but also impress them to win their trust. In contrast, Cristina stated that she focuses on the therapeutic relationship as the main vehicle of intervention

in treatments conducted in Spanish. She builds and fosters trust by allowing the therapeutic relationship to blossom, within acceptable boundaries. She believes that her monolingual Spanish-speaking clients, who at first appear resistant to interpretation, become more comfortable as the relationship develops and then are able to engage in more interpretive interventions. Antonella also reported that she tends to be more relational in her interventions with treatments she conducts in Spanish versus those conducted in English.

Cristina used the example of gifts to elaborate. She explained that receiving gifts is more culturally acceptable with her Latinx clients, who are also Spanish-speaking clients, than with her White, non-Latinx, U.S. American clients. This pattern in gift-giving behavior in psychotherapy has been reported in other studies as well (Sprowls & Biever, 2002). Cristina explained that she is less likely to interpret the gifts she receives in her treatments conducted in Spanish as having therapeutic meaning. She connected their gift-giving behavior to what is culturally acceptable within their professional relationship. In contrast, she is more likely to interpret the behavior of gift-giving from her monolingual English-speaking clients, who are more likely to identify as non-Latinx, U.S. American.

Thirdly, psychotherapists' assumptions about their clients depending on the language of treatment may also influence their choice of intervention. Miguel and Pablo reported that their monolingual Spanish-speaking clients have a lower educational level. They then believe that these clients require more psycho-education, as Miguel reported, or "pure counseling," as Pablo said. Their perception of these clients, related to the clients' educational background, affects the interventions these two clinicians choose to use. If Cristina's observation of her own monolingual Spanish-speaking clients, who also have lower educational levels, is applicable to other monolingual Spanish-speaking clients, then there could be other interventions, like interpretation,

that clinicians are neglecting to use with their monolingual Spanish-speaking clients due to their assumptions of what clients are able to tolerate or understand.

Limitations

The following limitations of this study should be considered to further understand the results and their implications for training and practice. The study chose to prioritize in depth interviews. Given constraints of time and other resources, a small sample size was recruited. The sample size of nine psychotherapists limits the study's generalizability. Participants also represent a convenience sample, working or studying in two neighboring states in the northeast region of the U.S., so the reported themes around training and supervision might be particular to the participants' geographic location.

The scope of the results is not only limited by the sample size, but also by the ethnicity and languages of the participants. All participants interviewed identified as Latinx or Hispanic. Interviewing non-Latinx, Spanish-English bilingual therapists might have provided a different perspective. Likewise, understanding the self- and other- experiences of bilingual psychotherapists who speak languages other than Spanish and English is likely to yield different themes, given the powerful connection between culture and language.

The client population served by the participants interviewed might have also impacted the results. A majority of the Spanish-speaking clients of all participants came from a lower socioeconomic class and lower educational background. Some phenomena described by participants, such as their assumptions about their clients and the intervention choices that followed, might have been different for Spanish-speaking clients from a different socioeconomic class and educational background. Moreover, this study did not explore the impact of practice settings on participants' reported experiences. Some participants interviewed practiced in

community clinics, while others provided therapeutic services in urban hospital settings and private practice offices. These different settings could pull for different clients, clinicians, and language-related experiences.

Another factor that may have impacted the results is participants' psychotherapy orientations. All participants identified as psychodynamically oriented or psychodynamically leaning. Interviewing psychotherapists predominantly practicing under other orientations, such as cognitive-behavioral or humanistic, might have yielded different data, possibly more in line with the orientations' principles and framework.

The interview questions and data collection tools also could have impacted these results. The wording of the semi-structured interview protocol may have set up a dichotomy for participants (English versus Spanish). This dichotomy could evoke experiences associated to language related self- and other- experiences that were less discrete than reported. The implied dichotomy could encourage participants to dismiss other grayer areas in their identity spectrum within the two languages.

The interviewer is the primary tool for data collection in qualitative research. This individual's background and biases influence data collection and analysis, as the study was developed based on the observations of the investigator's personal and professional experiences. She may have made assumptions about the participants' experiences instead of asking for clarification, explanations, or expansions during the interviews, assumptions that could have guided the data towards a specific answer or theme. Further, the time constraints in the participants' schedules also limited the level of detail and depth that participants included in their answers and that the investigator could request from them.

The interviews were conducted and transcribed in English, for a dissertation written in English. The language used for the data collection and reporting could have also impacted the data gathered. Had the interviews been conducted in Spanish, different answers may have been evoked. For example, participants could have remembered other aspects of their language-related self- and other experiences in psychotherapy and/or could have struggled to describe their experiences in the same level of detail if they experienced language anxiety at the time of the interview.

Implications for Training

Graduate training is likely the first time a psychotherapist learns clinical terms and concepts, making their language of training a first language for psychotherapy. This study sheds light on the importance of receiving training and supervision in the language of treatment. Language choice in training and supervision can impact self and professional development, and possibly the psychotherapeutic relationship and psychotherapy outcomes. The following suggestions for training bilingual clinicians relate to the explicit recommendations provided by some participants, and are also based on the experiences reported by other participants in this study on the benefits of receiving training in the language of practice.

Psychotherapy students would greatly benefit from being exposed to information about and research on the multiple ways that language impacts psychotherapy, both for clients and clinicians. This information should also include *how* language impacts self- and other- experiences personally and professionally for psychotherapists. The exposure could occur through a lesson within a diversity course, a supervision group, or a workshop. Linguistic diversity is lacking from most training curricula but is as important a topic of discussion as race, ethnicity, gender, and other aspects of identity.

As Espín (2013) expresses, the goal of this exposure can start with “plant[ing] a seed...invit[ing] therapists to ask themselves questions” about their language-related experiences (p. 24). Bilingual students should then be guided through a self-exploration similar to the one that other bilingual clinicians have embarked upon (Clauss, 1988; Pérez Foster, 1996; Walsh, 2014). The questions posed to participants in this study could serve as a guide. Alba and Isabella both remarked on how helpful the interview questions had been for them, prompting them to reflect on aspects of themselves and their practice that they would have otherwise not considered. Similarly, this self-exploration could raise awareness for bilingual students of how they experience themselves and others in their different languages, and help them make more purposeful choices around their interventions in treatment. Enhancing linguistic and cultural awareness can shed light on biases and assumptions that psychotherapists would otherwise not notice. Moreover, exposure to information and research can normalize students’ experiences, reduce self-doubts, increase perceived self-efficacy, and provide them with a hope for developing a more integrated psychotherapy self with practice and time, if that is their goal, or becoming a more purposeful practitioner when making intervention choices. Information can promote self-reflection and potentially shed light on linguistic weaknesses, encouraging psychotherapists to seek additional language training to strengthen their linguistic abilities and to provide more linguistically-competent services.

The self-exploration can also benefit bilingual or multilingual clients who might also experience language-related differences. More self-aware bilingual psychotherapists can help clients reflect on the multiple effects of language choice. Additionally, bilingual psychotherapists aware of how language impacts psychotherapy could also look for ways that language might be impacting the experiences of non-monolingual clients within and outside the treatment.

Biever, Castaño, De Las Fuentes et al. (2002) argue that services for Spanish speakers in the U.S. are often inadequate due to the lack of proper and formal training in the provision of mental health services in Spanish. They respond to the gap noted throughout the literature and delineate a model of training to provide mental health services in Spanish. Some programs have already developed a bicultural and bilingual specialty concentration, like Columbia University Teachers College's Bilingual Latino/a Mental Health Concentration through their Master's in Education degree. These programs are designed to meet the needs of the growing Spanish-dominant or bilingual community in the area and country as a whole. Although implementing the Biever et al. model might be helpful, the vast majority of training programs are unlikely to have the resources or motives to do so. Training students to provide psychotherapy and other mental health services in a language of practice other than English could be accomplished through a semester-long course and adjunct supervision in the language of the treatment for students or psychotherapists who already have a strong foundation of the language and are literate in that language. The reading material provided through this course should also be in the language of practice. Cristina and Isabella both spoke of how clinically and professionally beneficial reading clinical material in Spanish has been for them. If a course is not feasible for the training program, reading material in the language of practice could be provided through a supervision group.

Graduate students often learn best from seeing peers, professors, and/or supervisors conducting therapy. Cristina referred to the benefits of hearing her supervisors phrase interventions in the language of treatment, and of watching her colleagues and/or supervisors role playing a client-psychotherapist dyad and their interactions. A training institution or professional organization such as the American Psychological Association should create therapy videos of psychotherapy sessions conducted in Spanish and make them easily accessible and free for all

graduate students in mental health fields and psychotherapists. These videos would help enhance the students' training experience and strengthen their language competence in clinical terminology.

Practicum sites should also be made aware of the impact of language on therapy and practice, and should feel encouraged to provide training and supervision in the language of treatment when resources are available. The current limited number of bilingual psychotherapists in the country poses constraints on the number of students who can be supervised and trained by psychotherapists in a language of treatment other than English. Supervision groups at practicum sites or peer supervision groups for psychologists could help bridge the gap between supply and demand, given the growth of non-English speakers seeking mental health services across the country.

Implications for Practice

The American Psychological Association (APA) endorses the importance of providing culturally appropriate mental health services (APA, 2017; APA, 1990). The third guideline developed by the Task Force on Re-envisioning the Multicultural Guidelines for the 21st Century stresses that “psychologists strive to recognize and understand the role of language and communication through engagement that is sensitive to the lived experience of the individual, couple, family, group, community, and/or organizations with whom they interact. Psychologists also seek to understand how they bring their own language and communication to these interactions” (APA, 2017, p. 4). This guideline directly relates to the current study. It emphasizes the need for psychotherapists to explore the importance of language in psychotherapy both for themselves and their clients. Guideline 3 also calls for psychotherapists to develop self-awareness around their own language and communication with clients, and how language can and does

impact the psychotherapeutic process. A higher level of self-awareness around these issues, issues that include language-related differences in self- and other experiences, would likely lead to more purposeful intervention choices.

The sixth guideline in the former compilation of multicultural guidelines developed by the Task Force on the Delivery of Services to Ethnic Minority Populations emphasized that “psychologists [must] interact in the language requested by the client and, if this is not feasible, make an appropriate referral” (APA, 1993, p. 47). This guideline underscores the importance of language competence in psychotherapy. Supervisors, training directors, and hiring staff should continue to hold their students and licensed psychotherapists accountable for their language skills to ensure that they are able to provide the required services. Verdinelli and Biever (2009) recommend developing regulatory bodies to develop standards of practice around language competence, establishing the language proficiency required to provide services in a language other than the language of training. However, the goal of these recommendations is not to limit the number of language competent providers available. Implementing these suggestions should only be done after research and considerable thought is devoted to the possible impact of these added bureaucratic barriers on providing psychotherapeutic services in a language other than English. At this point in time, the costs may outweigh the benefits.

The issue of providing linguistically competent services versus not providing services at all comes into question. Is it better to provide mental health services at a lower language competency or not provide them at all? Future research should seek to address this dilemma and understand the factors impacting how clinicians or institutions choose between the two options, when given the choice. Using an interpreter, though more accessible than always finding a

linguistically competent provider, has its own issues and implications (see Raval & Tribe, 2014; Scott, 2014).

The current study also has implications for bilingual psychotherapy supervisors. Providing supervision in the language of the treatment being supervised is very important. If Spanish-speaking clinicians are providing psychotherapy in Spanish to their own clients, and are engaged in supervisory relationships with trainees but providing the supervision in English, they should be capable of switching the language of supervision to Spanish. Providing monolingual supervision for monolingual treatments will help psychotherapy students expand their vocabulary in the language of practice, especially when different from the language of training. Instead of using a clinical term in English when conducting supervision in another language, the supervisor and student could search for the term in the language of treatment together. Developing an understanding of the client in the language of treatment could not only enhance the language competency of the psychotherapy student, but could also help reduce their second language anxiety, improve their perceived self-efficacy about providing services in that language, reduce the emotional distance experienced in session as a result of the internal translation required to deliver certain interventions learned in English, and have other small or large benefits that might have not been outlined in this study.

Suggestions for Future Research

The suggestions for future research stem from the results of this study and the limitations of the study outlined above. Other studies could examine the ubiquity of the reported language-related self- and other experiences in bilingual psychotherapists across the country. That study could take the form of a survey or another quantitative approach focused on breadth rather than depth. Future research could also focus on other language combinations for bilingual and

multilingual psychotherapists, examining if and how the phenomena outlined in this study are specifically related to Spanish-English bilinguals through their connection to those specific two languages, or are generalizable to other kinds of bilingual psychotherapists.

As outlined throughout this study, many other small qualitative studies (Alonzo, 2007; Sprowls & Biever, 2002; Verdelli & Biever, 2009; etc.) share the recommendations for changes in training and practice outlined above. It is essential to understand, through future research, the barriers that exist to implementing these changes. The need for linguistically-competent mental health services has been documented for decades in the research, making the need for linguistically-competent psychotherapists clear. Some questions to be explored in this study could include the following: Why are supervisors who provide services in Spanish or another second language not supervising in the language of treatment? If clinical psychology courses in Spanish exist in Spanish-speaking countries, Argentina being at the forefront of psychodynamic theory with other major cities worldwide, what local and/or political issues prevent clinical material in Spanish from being taught in U.S. American institutions? An article with the goal of implementation and policy change should compile results from similar studies, making a stronger, and more persuasive statement through the aggregation of existing work.

Another important topic that needs to be studied is the impact of these language-related self- and other experiences on the psychotherapeutic relationship and psychotherapy outcomes. Clauss (1988) alludes to this question in her own suggestions for future research: "Future research should consider how issues of transference and countertransference in like-matched bilingual psychotherapy affect psychotherapy process and outcome" (p. 195). This study's original research questions included that goal, but the following barriers restricted the information gathered around this topic: limitations in the participants' self-awareness, possible issues associated with hindsight

bias, reluctance to share personal material in a relatively brief interview, and possibly shame or embarrassment that arose as a result of participants' feeling questioned about the variation in efficacy as clinicians depending on the language of practice. Better measures and/or tactful questions need to be developed in order to explore this issue.

On a broader level, the findings of this study highlight the importance of increasing psychotherapists' awareness of the impact of language, and specifically the bilingualism of the psychotherapist, on the therapeutic experience. This study also underscores how better addressing the areas of linguistic competence and self- and other-related linguistic experiences can help the mental health fields move towards upholding standards of self-awareness.

The findings of this study argue that there are specific ways that can be implemented to improve the provision of mental health services for the ever-growing and underserved population of non-English speakers in the United States, including but not limited to training bilingual psychotherapy students on the impact of language on psychotherapy and providing training and supervision in the language of practice.

References

- Abutalebi, J., Cappa, S. F., & Perani, D. (2001). The bilingual brain as revealed by functional neuroimaging. *Bilingualism: Language and cognition*, 4(2), 179-190.
- Alonzo, M. A. (2007). *Understanding the role of language in the psychotherapeutic process: Exploring the bilingual clinician's linguistic experience*. ProQuest.
- Altarriba, J. (2003). Does *cariño* equal “liking”? A theoretical approach to conceptual nonequivalence between languages. *The International Journal of Bilingualism*, 7(3), 305-322.
- Altarriba, J., & Santiago-Rivera, A. L. (1994). Current perspectives on using linguistic and cultural factors in counseling the Hispanic client. *Professional Psychology: Research and Practice*, 25, 388–397.
- American Psychological Association. (1993). Guidelines for providers of psychological services to ethnic, linguistic, and culturally diverse populations. *American Psychologist*, 48(1), 45–48. <https://doi.org/10.1037/0003-066X.48.1.45>
- American Psychological Association. (2017). *Multicultural Guidelines: An Ecological Approach to Context, Identity, and Intersectionality*. Retrieved from: <http://www.apa.org/about/policy/multicultural-guidelines.pdf>
- Bandura, A. (2010). Self-efficacy. *The Corsini encyclopedia of psychology*, 1-3.
- Biever, J., Castaño, M., De Las Fuentes, C., González, C., Servín-López, S., Sprowls, C., ... Kenkel, M. (2002). The role of language in training psychologists to work with Hispanic clients. *Professional Psychology: Research and Practice*, 33(3), 330–336. <https://doi.org/10.1037/0735-7028.33.3.330>
- Bowker, P., & Richards, B. (2004). Speaking the same language? A qualitative study of

- therapists' experiences of working in English with proficient bilingual clients. *Psychodynamic Practice*, 10(4), 459-478.
- Buxbaum, E. (1949). The role of a second language in the formation of ego and superego. *The Psychoanalytic Quarterly*, 18(3), 279-289.
- Castaño, M. T., Biever, J. L., González, C. G., & Anderson, K. B. (2007). Challenges of providing mental health services in Spanish. *Professional Psychology: Research and Practice*, 38(6), 667.
- Clauss, C. S. (1998). Language: The unspoken variable in psychotherapy practice. *Psychotherapy: Theory, research, practice, training*, 35(2), 188.
- Corbin, J., & Strauss, A. (1990). Grounded theory research: Procedures, canons and evaluative criteria. *Zeitschrift für Soziologie*, 19(6), 418-427.
- Costa, A., Vives, M. L., & Corey, J. D. (2017). On Language Processing Shaping Decision Making. *Current Directions in Psychological Science*, 26(2), 146-151.
- de Courtivron, I. (2003). *Lives in translation: Bilingual writers on identity and creativity*. N.Y.: Palgrave Macmillan.
- De Zulueta, F. (1995). Bilingualism, culture and identity. *Group Analysis*, 28(2), 179-190.
- Dingfelder, S. F. (2005). Closing the gap for Latino patients. *Monitor on Psychology*, 36(1), 58-61.
- Duff, P. A., & Uchida, Y. (1997). The negotiation of teachers' sociocultural identities and practices in postsecondary EFL classrooms. *Tesol Quarterly*, 31(3), 451-486.
- Espín, O. M. (2013). "Making Love in English:" Language in Psychotherapy with Immigrant Women. *Women & Therapy*, 36(3-4), 198-218.
- Findling, J. (1969). Bilingual need affiliation and future orientation in extragroup and intragroup

- domains. *The Modern Language Journal*, 53(4), 227-231.
- Glaser, B., & Strauss, A. (1967). *The discovery of grounded theory: Strategies for qualitative research*. Chicago: Aldine.
- Greenson, R. R. (1950). The mother tongue and the mother. *The International Journal of Psycho-Analysis*, 31, 18.
- Gutfreund, D. C. (1990). Effects of language usage on the emotional experience of Spanish–English and English–Spanish bilinguals. *Journal of Consulting and Clinical Psychology*, 58, 604–607.
- Guarnaccia, P. J., & Rodriguez, O. (1996). Concepts of culture and their role in the development of culturally competent mental health services. *Hispanic journal of behavioral sciences*, 18(4), 419-443.
- Hoffman, E. (1989). *Lost in translation: A life in a new language*. New York; Markham, Ont.: Penguin Books.
- Javier, R. A. (2007). *The bilingual mind: Thinking, feeling and speaking in two languages*. Springer Science & Business Media.
- Javier, R., Barroso, F., & Muñoz, M. (1993). Autobiographical memory in bilinguals. *Journal of Psycholinguistic Research*, 22 (3), 319-338.
- Lijtmaer, R. M. (1999). Language shift and bilinguals: Transference and countertransference implications. *Journal of the American Academy of Psychoanalysis*, 27(4), 611.
- Luk, G., Green, D. W., Abutalebi, J., & Grady, C. (2012). Cognitive control for language switching in bilinguals: A quantitative meta-analysis of functional neuroimaging studies. *Language and cognitive processes*, 27(10), 1479-1488.
- MacIntyre, P. D., & Gardner, R. C. (1994). The subtle effects of language anxiety on cognitive

- processing in the second language. *Language learning*, 44(2), 283-305.
- Marcos, L. R. (1976). The linguistic dimensions of the bilingual patient. *American Journal of Psychoanalysis*, 36, 347-354.
- Marcos, L. R. Eisma, J. E. & Guimon, J. (1977), Bilingualism and the sense of self. *American Journal of Psychoanalysis*, 37: 285-290.
- Marcos, L. R. & Urcuyo, L. (1979). Doing psychotherapy with the bilingual patient. *American Journal of Psychotherapy*, 33(3), 331-338.
- Marcos, L. R. (1980). Bilinguals in psychotherapy. *Psycholinguistics in Clinical Practice*, 91-108.
- Marcos, L. R. (1988). Understanding ethnicity in psychotherapy with Hispanic patients. *American Journal of Psychoanalysis*, 48, 35-42.
- Marian, V., & Neisser, U. (2000). Language-dependent recall of autobiographical memories. *Journal of Experimental Psychology: General*, 129(3), 361.
- McCracken, G. (1988). *The long interview* (Vol. 13). Sage.
- Movahedi, S. (1996). Metalinguistic analysis of therapeutic discourse: Flight into a second language when the analyst and the analysand are multilingual. *Journal of the American Psychoanalytic Association*, 44(3), 837-862.
- Nida, E. (1998). Language, culture, and translation. *Journal of Foreign languages*, 3, 29-33.
- Norton, B. (1997). Language, identity, and the ownership of English. *TESOL quarterly*, 31(3), 409-429.
- Ogden, T. H. (1993). *The matrix of the mind: Object relations and the psychoanalytic dialogue*. Jason Aronson.
- Perez Foster, R. (1992). Psychoanalysis and the bilingual patient: Some observations on the

- influence of language choice on the transference. *Psychoanalytic Psychology*, 9(1), 61.
- Perez Foster, R. (1996). The bilingual self: Duet in two voices. *Psychoanalytic Dialogues*, 6(1), 99-121.
- Pitta, P., Marcos, L. R., & Alpert, M. (1978). Language switching as a treatment strategy with bilingual patients. *The American Journal of Psychoanalysis*, 38(3), 255-258.
- Potter, W. (1996). An Analysis of Thinking and Research about Qualitative Methods. Mahwah, NJ: Lawrence Erlbaum Associates.
- Raval, H., & Tribe, R. (2014). *Working with interpreters in mental health*. Routledge.
- Richards, L., & Morse, J. M. (2012). *Readme first for a user's guide to qualitative methods*. Sage.
- Rosenblum, S. M. (2011). The role of language in therapy: How bilingual/multilingual therapists experience their work with bilingual/multilingual clients.
- Schrauf, R. W., & Rubin, D. C. (2000). Internal languages of retrieval: The bilingual encoding of memories for the personal past. *Memory & Cognition*, 28(4), 616-623.
- Schrauf, R. W., Pavlenko, A., & Dewaele, J. M. (2003). Bilingual episodic memory: An introduction. *International Journal of Bilingualism*, 7(3), 221-233.
- Scott, S. D. (2014). *Clinician factors in interpreter-facilitated psychotherapy: an exploratory study* (Doctoral dissertation, Rutgers University-Graduate School of Applied and Professional Psychology).
- Sprowls, C., & Biever, J. (2002). *Bilingual therapists' perspectives of their language-related self-experience during therapy*. ProQuest Dissertations Publishing. Retrieved from <http://search.proquest.com/docview/305442234/>
- Stern, M. (1993, April 17). The subjective and intersubjective experience of switching languages

in analytic treatment. In *13th annual meeting of the Division of Psychoanalysis (39) of the American Psychological Association*.

- Stringer, H. (2015, April). Se solicita: Psicólogos que hablen Español (Wanted: Spanish-speaking psychologists). *gradPSYCH Magazine*. Retrieved from <http://www.apa.org/gradpsych/2015/04/spanish-speaking.aspx>
- Sue, S. (1988). Psychotherapeutic services for ethnic minorities: Two decades of research findings. *American Psychologist, 43*(4), 301.
- Sue, D. W., Arredondo, P., & McDavis, R. J. (1992). Multicultural counseling competencies and standards: A call to the profession. *Journal of Counseling & Development, 70*(4), 477-486.
- Tervalon, M., & Murray-Garcia, J. (1998). Cultural humility versus cultural competence: A critical distinction in defining physician training outcomes in multicultural education. *Journal of health care for the poor and underserved, 9*(2), 117-125.
- Trepal, H., Ivers, N., & Lopez, A. (2014). Students' experiences with bilingual counseling. *The Journal of Counselor Preparation and Supervision, 6*(2), 2.
- Valdez, J. N. (2000). Psychotherapy with bicultural Hispanic clients. *Psychotherapy: theory, research, practice, training, 37*(3), 240.
- Verdinelli, S., & Biever, J. L. (2009). Spanish–English bilingual psychotherapists: Personal and professional language development and use. *Cultural Diversity and Ethnic Minority Psychology, 15*(3), 230.
- Walsh, S. D. (2014). The bilingual therapist and transference to language: Language use in therapy and its relationship to object relational context. *Psychoanalytic Dialogues, 24*(1), 56-71.

Appendix A

Subject Recruitment E-mail

My name is Pauline Levy and I am a doctoral student in the department of clinical psychology at Rutgers University, and I am conducting interviews for my dissertation. I am studying the linguistic experience of practicing bilingual therapists and its impact on the therapeutic process. More specifically, this study focuses on the sense of identity of bilingual psychotherapists who have conducted treatment in English and Spanish. It is designed to explore the extent to which your experiences vary depending on the language of a given treatment. Do you work differently, or feel different about yourself, depending on which language you use?

During this study, participants will be asked to fill out a demographic questionnaire and to answer some questions about their experiences as a bilingual psychotherapist in and outside their psychotherapy practice.

The benefits of taking part in this study may include an increased understanding of your language-related identities and their impact on your psychotherapy style. An increased self-awareness as a bilingual psychotherapist could in turn equip you with greater flexibility and choice in their therapeutic style. The study might also help in elucidating future areas of research, training, and practice.

Four screening questions will determine if you [the reader] would be eligible to participate in the study:

1. Are you a licensed practicing therapist or an advanced predoctoral or postdoctoral therapist practicing under the supervision of a licensed therapist?
2. Do you self-identify as a psychodynamic psychotherapist?
3. Are you bilingual in English and Spanish?
4. Have you conducted individual psychotherapy in each language (English and Spanish) with at least five (5) clients (for longer than 3 sessions each)?

If you have answered yes to the four screening questions and you are interested in participating in this study, then please contact me, Pauline Levy Frydman, at pauline.levy@gsapp.rutgers.edu. Interviews are expected to take from 60 to 90 minutes. In-person interviews can be scheduled in an office in Piscataway, New Jersey, or a private space of your choosing. This study has been approved by the Rutgers' Internal Review Board. If you have any questions about this study, please do not hesitate to ask. Thank you for your time and attention.

Sincerely,

Pauline Levy Frydman, Psy.M.

Appendix B

Letter of Informed Consent

Interview Consent Form with Audio/Visual Recording

I am a doctoral student in the department of clinical psychology at Rutgers University, and I am conducting interviews for my dissertation. I am studying the linguistic experience of practicing bilingual therapists and its impact on the therapeutic process. More specifically, this study focuses on the sense of identity of bilingual psychotherapists who have conducted treatment in English and Spanish. It is designed to explore the extent to which your experiences vary depending on the language of a given treatment. Do you work differently, or feel different about yourself, depending on which language you use?

During this study, you will be asked to fill out a demographic questionnaire and to answer some questions about your experiences as a bilingual psychotherapist in and outside your psychotherapy practice. This interview was designed to be approximately one and a half hours in length. However, please feel free to expand on the topic or talk about related ideas. Also, if there are any questions you would rather not answer or that you do not feel comfortable answering, please say so and we will stop the interview or move on to the next question, whichever you prefer.

This research is confidential. Confidential means that the research records will include some information about you, however, any identifying information will be separated from your responses. The information gathered will be kept confidential by assigning you an ID code or a pseudonym of your choice. That master list that links any identifying information to your code will be kept separately in a locked cabinet. The data gathered in this study are confidential with respect to your personal identity unless you specify otherwise.

All interviews will be audio recorded, and agreeing to the recordings is a condition of agreeing to participate. The recording(s) will be used for analysis by the research team to answer the research question. The transcripts of the recordings will be generated through a computer software without additional human involvement.

The recording(s) will include your name. All names will be deleted in the transcript, as well as written dissertation, and pseudonyms will be given. If you say anything that you believe at a later point may be hurtful and/or damage your reputation, you can ask the interviewer to rewind the recording and record over such information OR you can ask that certain text be removed from the dataset/transcripts.

The recording(s) will be stored in a password-protected file on a password-protected laptop. The recordings will be kept until the end of the study (no more than 3 years), and will then be destroyed.

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, only de-identified results will be stated. All study data will be destroyed three years after completion of the study.

Risks:

The interview asks you to describe your experiences with working psychotherapeutically in two languages. The questions are likely to be questions you will have already thought of and possibly addressed during your training and supervision as a psychodynamic psychotherapist. They might elicit some short-term discomfort. If the subject matter during the interview becomes upsetting the investigator, as a trained clinician, will assist you in dealing with these feelings and make appropriate professional referrals. If you experience emotional distress related to the study after the interview has concluded, please contact the researcher and discuss this with her, so that she can assist you and help provide you with referrals as necessary.

Benefits:

The benefits of taking part in this study may include an increased understanding of your language-related identities and their impact on your psychotherapy style. An increased self-awareness as a bilingual psychotherapist could in turn equip you with greater flexibility and choice in their therapeutic style. The study might also help in elucidating future areas of research, training, and practice. However, you may receive no direct benefit from taking part in this study.

You are aware that **your participation in this interview is voluntary**. You understand the intent and purpose of this research. If, for any reason, at any time, you wish to stop the interview, you may do so without penalty and without having to give an explanation.

If you have any questions about the study or study procedures, you may contact me at:

Pauline Levy Frydman, Psy.M. Principal Investigator Rutgers University, GSAPP 152
Frelinghuysen Road Piscataway, NJ 08854-8085 Telephone: (646) 584-1352 Email:
pl416@gsapp.rutgers.edu

You can also contact my dissertation chair:

Karen Riggs Skean, Psy.D. Professor at Rutgers University, GSAPP 152 Frelinghuysen Road
Piscataway, NJ 08854-8085 Telephone: (732) 247-7489 Email: kskean@aol.com

If you have any questions about your rights as a research participant, you can contact the Institutional Review Board at Rutgers (which is a committee that reviews research studies to

protect research participants).

Institutional Review Board Rutgers University, the State University of New Jersey Liberty Plaza
335 George Street, 3rd Floor, Suite 3200, New Brunswick, NJ 08901

Phone: 732-235-2866 Email: humansubjects@orsp.rutgers.edu

You will be offered a copy of this consent form that you may keep for your own reference.

Once you have read the above form and, with the understanding that you can withdraw at any time and for whatever reason, you need to let me know your decision to participate in today's interview.

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.

Subject (Print) _____ Subject Signature
_____ Date _____

Principal Investigator Signature _____ Date _____

You will be given a copy of this consent form for your records. By participating in the above stated procedures, then you agree to participation in this study.

Appendix C

Interview Guide

Background information and demographics:

- How old are you?
- Where were you born? (state or country if outside the U.S.)
- Where is your family originally from?
- How would you describe your ethnicity?
- How many years have you been working as a licensed therapist?
- What populations have you worked with?
- Education
 - What is your degree? (MSW, PsyD, PhD, MA, etc.)
 - How would you describe your orientation/treatment approach?

Language History

- At what age did you learn English? Spanish?
- In what context did you learn English? Spanish?
- In what language do you live?
 - With whom do you speak English outside the office? Spanish?
 - What language do you speak in your own therapy?
- What comes to mind when you think of the English language? Of U.S. American culture and U.S. Americans?
- What comes to mind when you think of the Spanish language? Of your family's culture of origin and citizens from that country?
- What was the primary language of your training? During the course of pursuing your advanced mental health degree, did you have any training or supervised experience working in the other language?
- Would you say that your languages and your dream life are related? How?
 - When do you dream in Spanish? English?
 - Are there any patterns you have noticed for when you dream in each language?

Language Usage in Treatment

- How do you feel as a therapist when you speak English?
- How do you feel as a therapist when you speak Spanish?
- Do you experience language-related identity differences?
- Have you noticed patterns in your ways of working with clients depending on the language of practice?
- How does your countertransference vary depending on the language, on average?
 - Vulnerability
 - Access to your emotions
 - Emotional expression
 - Willingness to and practice of self-disclosure
 - How does your body feel when you speak English?
 - How does your body feel when you speak Spanish?

- How do you think they affect the therapeutic space?
- When working in English, are there certain Spanish words or expressions you find yourself missing?
- When working in Spanish, are there certain Spanish words or expressions you find yourself missing?
- What are three words that describe your therapeutic style [or your sense of yourself as a therapist] in English?
- What are three words that describe your therapeutic style [or your sense of yourself as a therapist] in Spanish?