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Sara Esther Walker
An Exploration of White
Mental Health Clinicians'
Provision of Spanish
Language Services to
Latino/a Clients

ABSTRACT

This study explored White mental health clinicians' provision of services in Spanish to Latino/a clients through exploratory interviews with thirteen clinicians. Participants were asked about their identities as White Spanish speakers and their motivations to provide services in Spanish. They were asked how clients, colleagues, and supervisors respond to them as White Spanish speakers. Challenging aspects of their work were explored, as were any instances in which they felt advantaged by their White identities. Finally, participants were asked about differences in the quality of care that they offer in English versus Spanish, and additional support or training that would help them improve the quality of the Spanish language services that they provide.

The findings of this study suggest that White, Spanish-speaking clinicians see both opportunity and challenge in their work. They tend to find cross-linguistic, cross-cultural work challenging throughout their careers, with linguistic challenges being more central earlier in their professional development, and cultural challenges becoming more prevalent later on. Participants tended to receive appreciative and complimentary feedback from clients, peers, and supervisors. However, most indicated that the quality of services they provide in Spanish is lower than the quality of services they provide in English. Participants received most of their training specific to providing clinical services in Spanish independently of any formal clinical training or employer. They

would benefit, as would the clients they serve, from increased opportunities for support and training specific to Spanish language work in their clinical training programs and in their agencies of employment.

AN EXPLORATION OF WHITE MENTAL HEALTH CLINICIANS' PROVISION OF
SPANISH LANGUAGE SERVICES TO LATINO/A CLIENTS

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2009

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For many participants in this study, learning Spanish and choosing to provide clinical mental health services in Spanish shifted the course of their careers and their lives. Conceiving of and conducting this research project has steadied me on a similar course, with new learning like a rudder for the challenges that are to come. I would like to thank all those in my life- family, friends, colleagues, teachers, mentors, clients- who have encouraged and supported me in my process of learning Spanish, learning to be a social worker, and learning to combine the two, including in the process of conducting this research project. I would like to thank my advisor, Fred Newdom, who guided me with patience and an eye for the big picture as my ideas shifted into a project, and then, into written form. Finally, I would like to thank those clinicians who were gracious enough to share their experiences with me as participants in this study.

Gracias.

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CHAPTER I

INTRODUCTION

The Latino ethnic group, the fastest-growing ethnic group in the United States (U.S. Census, 2001), is comprised of a diverse conglomeration of individuals whose language dominance falls everywhere on the spectrum between dominance in English, dominance in Spanish, and varying degrees of English/Spanish bilingualism, among other language combinations. Language dominance, or the language in which a person communicates most proficiently, depends on a variety of factors, including education, immigration history, and level of immersion in Latino/a communities. To meet the mental health needs of those Latino/as who are dominant in Spanish, clinicians of many racial identities who have Spanish language skills, including White clinicians, are currently providing services in Spanish. Their contributions expand accessibility of services to an underserved population. At the same time, numerous challenges may arise when White clinicians who have learned Spanish as a second language provide these services. A clinician's training, support within the work environment, and internal resources will impact his or her preparation to negotiate these challenges. The goal of this study is to collect data to help clinicians, clinical training programs, and employers more accurately assess challenges to providing cross-linguistic, cross-cultural care, and assess how all parties can work towards managing these challenges, thus improving quality of care for Spanish-dominant clients.

The focus of this project is informed by ethical and professional guidelines of culturally competent cross-linguistic clinical services, as described in the National Association for Social Workers' document, "NASW Standards for Cultural Competence in Social Work Practice" (NASW, 2001). According to this document, "Language diversity is a resource for society, and linguistic diversity should be preserved and promoted. The essence of the social work profession is to promote social justice and eliminate discrimination and oppression based on linguistic or other diversities." In this statement, the NASW names promoting linguistic diversity as a central component of the ethical and professional responsibilities for culturally competent social workers. It follows that one aspect of promoting linguistic diversity is to encourage and contribute to the provision of clinical services in languages other than English. However, eliminating linguistic-based discrimination and oppression in clinical service provision does not stop with services being provided in multiple languages. Ethical service provision necessitates that services in languages other than English not only are offered, but are also accessible and high in quality. An expectation of high quality care places special demands on clinicians who are functionally bilingual, but whose skills in English versus their second language are not equal. How can one meet the ethical obligation to provide high-quality clinical services in one's second language?

The responsibility for ensuring that White clinicians who provide services in Spanish provide high-quality services falls not only on individual clinicians, but also, on the programs that train and agencies that employ these clinicians. White clinicians with skills in Spanish have a tool that they can use to promote social justice and reduce discrimination for Latino/a, Spanish-dominant clients. However, this tool only achieves

its intended purpose when it is used in the service of the client. When White mental health clinicians with sub-fluent Spanish language abilities and little to no professional training in Spanish are asked to provide Spanish-language services, they face a difficult ethical challenge. These clinicians may find themselves choosing between serving clients with the limited language skills they have and denying clients care. The emphasis on this choice ignores the structural realities of why so few Latino/a Spanish-speaking people are qualified to provide clinical mental health services, why so few non-Latino/a clinicians are fluent in Spanish, and why Spanish language professional training for all clinicians is so scarce. This study seeks to expand current knowledge of cross-racial, cross-linguistic mental health care with White clinicians and Latino/a clients by shifting the focal point of inquiry from the individual, Spanish-dominant client's needs, to more particular inquiry into the White clinician's motivations and decision-making, as well as a wider-lens exploration of a variety of dynamics that influence cross-linguistic care, including clinical training and agency support.

This researcher has made a choice to focus on dynamics that are particular to the White clinician's provision of Spanish-language services to Latino/a clients. Some of the dynamics of service provision within this dyad may parallel dynamics in other dyads, like when an African American clinician provides Spanish language services to Latino/a clients, or when a White clinician provides Cantonese language services to Chinese American clients. However, there are also differences in dynamics between dyads of different racial and ethnic compositions, based on the larger sociopolitical context in which each dyad interacts. In the case of the White clinician and the Spanish-dominant Latino/a client, the politics of immigrant rights and anti-immigration movements are very

much present. In the immigrant rights movement, Latino/a people are located as the face and the voice of the movement, while White people, often, are located as the oppressors. On the other hand, in the anti-immigration and English-only movements, White people are located as the face and the voice of the movements, while Latino/a people, and especially Spanish-speaking Latino/a people, are located as the immigration “problem.” Thus, each time a Latino/a client faces a White clinician in a clinical setting, he or she is facing someone who looks like his or her oppressor. If the client is to receive a useful treatment, he or she must trust the possibility that the clinician is, in fact, different from those in the oppressor role with whom he or she has previously interacted. In time, the clinician must provide evidence, through goodwill, and through the words of the client’s native language, that this is true. Because the dynamics of this particular clinician-client dyad will better be understood as patterns begin to emerge in this and other research, the researcher chose to limit the focus of this research to this specific dyad to render a sample size adequate to assess some themes and patterning.

The limiting of the sample to a specific cross-cultural, cross-linguistic dyad will not, of course, yield a monolithic sample. “Latino” is an umbrella term that is used to refer to Spanish-speaking immigrants from Latin America and their descendents. “Latino/a”, pronounced Latino and Latina, is used in this study to refer to both men and women within the group, and avoid bias in using the masculine term to refer to both sexes. It should be noted that Spanish-dominant Latino/a clients are very diverse in terms of their nationality, racial identification, cultural identification, linguistic background and skills, and immigration status. Thus, the phrases “Latino/a cultures” and “Latino/a communities” are used in this study in the plural form to suggest the existence of various

groupings within the Latino/a umbrella. Also, each member of the clinical dyad in question carries many other identity components with them into the therapeutic relationship, including socioeconomic status, religion, sex, gender, sexual orientation, ability, and more. Thus, there are many different combinations of similarity and difference in the clinical dyad even when the sample is restricted in the ways that it is in this study.

CHAPTER II

LITERATURE REVIEW

This literature review examines existing materials that contribute to an understanding of the dynamics around White clinicians' provision of Spanish language services to Latino/a clients. First, the socio-political context that informs dynamics in this therapeutic dyad is explored. Next, literature is reviewed relating to best practices for Spanish-dominant clients. Then, the potential contributions that White clinicians can make in providing Spanish-language services are reviewed. The challenges that arise when White clinicians provide Spanish-language services are explored. Finally, the contributions that training programs, and then mental health agencies, can make in supporting clinicians in meeting these challenges are considered. Gaps in existing research are discussed to lay the ground for the content of this study.

Demographic Factors in the Need for Spanish Language Services

In considering the socio-political context that informs dynamics in Spanish language mental health services, we begin with a consideration of why it is that Spanish-language therapy is increasingly in demand in the United States. The population of Latino/as in the United States is rapidly growing due both to immigration and new births. A 2007 U.S. Census Bureau news release notes that the census of foreign-born U.S. residents reached an all-time high in 2007 of 38.1 million individuals (U.S. Census Bureau, 2007). While Latino/as comprised just 15.1% of the U.S. population in 2007,

they comprised just over half of the total U.S. population growth, or 50.5%, from 2000 to 2008 (Fry, 2008). The Latino/a population is expected to continue to grow rapidly. A PEW Research Foundation study projects that the Latino/a population will triple in size between 2005 and 2050 (Passel & Cohn, 2008), to comprise 29% of the U.S. population in 2050. Also in 2050, White Americans are expected to become a statistical minority (47%). Those Latino/as who have immigrated to the U.S. are most likely to have dominance in Spanish. According to net analysis of surveys of 14,000 Latino/as, 23% of Latino/a immigrants report that they speak English very well, while 88% of their U.S.-born children report that they speak English very well (Hakimzadeh & Cohn, 2007). These figures probably underestimate the percentage of the Latino/a immigrant population that is dominant in Spanish, as some portion of the 23% of immigrants who report that they speak English very well will also report that communicate in their native Spanish most proficiently. The state of California, which is the focus of this study, is the state that is home to the largest percentage of the Latino/a population in the U.S., with 31% of all U.S. Latino/as residing in California (PEW Hispanic Center, 2004). Mexican Americans comprise the largest percentage of the Latino/a Californian population at 84%.

Access to Care and Utilization of Services for Spanish Speakers

With the census of Spanish-speaking Latino/as in the U.S. growing rapidly, one might predict that the census of Spanish-speaking Latino/as presenting for mental health care services would also be on the rise. However, this is not evident to the extent that one might predict. Discrepancies in access to care for Spanish speakers, and in need for care for Spanish speakers, both seem to impact Spanish-speaking Latino/as presenting for mental health services in lower numbers than White Americans.

Research shows that Latino/as do not access mental health services at the same rates as their White peers, even when adjusting for rates of diagnosable psychiatric disorder. One study (Alegría et al., 2002) indicates that, of those participants who met criteria for an assessed psychiatric disorder in the previous year, 5.9% of Latino/as, compared with 11.8% of Whites, received specialty mental health care. Because Latino/as have, on average, fewer financial resources than White Americans, many consequently lack health insurance, a major deterrent to accessing services. A 1999 report indicated that 37% of Latino/as are uninsured, which is more than double the percent for Whites (U.S. Department of Health and Human Services, 1999). Physical, cultural, and linguistic barriers also discourage Latino/as from accessing care (Alegría et al., 2002). Physical and structural barriers to care include lack of proximity to care facilities for those living in Latino/a neighborhoods and poor access to facilities by public transportation. Cultural barriers include providers' lack of knowledge and skill in working competently with Latino/a populations, as well as a bias in Latino/a communities against formal mental health treatment, with a preference for alternative, more culturally congruent means of treatment. Linguistic barriers include limits in availability or quality of Spanish language services within providing agencies.

Some studies suggest that part of the reason that Latino/as access mental health services comparatively less often than their White peers may have to do with Latino/as suffering less psychiatric disorder. A major study (Alegría et al., 2008) indicates that lifetime prevalence rates of psychiatric disorders are lower from Latino/as than for Whites. The study found that 29.7% of Latino/a participants report a lifetime psychiatric disorder, as compared to 43.2% of White participants. Prevalence rates for Latino/a

immigrants are found to be even lower. The same study finds that 24.9% of Latino/a immigrants report a lifetime psychiatric disorder, compared with 37.1% of U.S.-born Latino/as. Even more strikingly, 20.4% of U.S.-born Latino/as report a lifetime prevalence of a substance abuse disorder, compared to 7% of Latino/a immigrants. The authors suggest that protective factors in Latino/a cultures like positive reframing, denial, religion and close family networks, may decrease the likelihood of individuals developing a psychiatric disorder. Conversely, the dominant culture in the U.S. tends to be more productivity-driven, and to encourage self-medication with substances as a means of coping with the stress of meeting these standards. Thus, the more time a Latino/a person spends in the U.S., the more likely that he or she is to develop a psychiatric disorder. Another major study, the National Comorbidity Study, confirms that Mexican Americans experience fewer lifetime disorders compared with White Americans (U.S. Department of Health and Human Services, 1999). A third major study found that Mexican Americans and White Americans have similar rates of psychiatric disorders, but when the Mexican American cohort was sub-grouped into Mexican-born and U.S.-born groups, those born in the U.S. had higher rates of depression and phobias compared with those born in Mexico (U.S. Department of Health and Human Services, 1999). Therefore, it may be, in part, that Spanish-speaking Latino/as do not present as often for psychiatric treatment because they are not in as much need in terms of psychiatric disorder.

Still, one must wonder whether the tools used in these studies, and the psychiatric diagnostic system in the U.S. in general, accurately assesses the degree of psychological distress that the Latino/a population faces. Many Latino/as may benefit from some kind

of mental health care not only for the treatment of psychiatric disorders, but also, for support with coping with traumatic environmental conditions and experiences that do more frequently affect Latino/a populations. According to one study (Altarriba & Santiago-Rivera, 1994), Latino/as experience high degrees of stress. Language barrier difficulties confine Latino/as to more homogenous neighborhoods and communities, and limit access to goods and services, including education and healthcare. Family power structures shift in ways that are difficult for the entire family system when children learn English at a faster rate than their parents due to increased exposure, often resulting in rifts between the generations or undue responsibilities falling upon the children. Poverty exposes families to violence, illness, poor nutrition, dangerous and unsatisfactory working and living conditions, and lack of money and time for more fulfilling life activities, including self-care activities. Many of the Latino/a immigrants who are newest to the United States are most lacking in financial and material resources and access to basic life needs, including healthcare and education. According to the 2000 census, 22.6% of all Latino/a families were living below the poverty line (U.S. Census Bureau, 2001). Discrimination, ranging from microaggressions around social interactions to macro aggressions around housing and violence, engenders ongoing stressful and traumatic experiences. One might hypothesize that these stress factors are even more prevalent in the Spanish-dominant Latino/as considered here, as this group includes more recent immigrants who have recently endured the stress, major life changes, and often, the danger posed by immigration. The combination of these factors at once exposes individuals and communities to great deals of stress and trauma, and robs them of the time and resources to adequately cope with these experiences. Thus, while Latino/as, and

particularly Latino/a immigrants, may experience psychiatric disorder as defined by the DSM at lower rates than White Americans, it is reasonable to consider that many experience psychological distress, and many more could benefit from mental health services than are currently presenting for treatment.

Many of the same factors that increase the environmental stress in Latino/a communities, including poverty and lack of access to education, also contribute to Latino/as not being proportionally represented in many higher-skilled professions, including as mental health practitioners. A study by the U.S. Department of Education (U.S. Department of Education, 2006) indicates that, in California in 2006, 70.7% of graduates of doctorate and master's-level clinical, counseling, and general psychology programs were White, while 11.9% were Latino/a. With 32.4% of the California population identifying as Latino/a in the 2000 census (U.S. Census Bureau, 2001), and that population steadily increasing, this means that Latino/as are significantly underrepresented as mental health care providers. When considering the mental health care needs of Latino/as who are dominant in Spanish, this is unfortunate for a number of reasons. First, those Latino/as who are native Spanish speakers have a large advantage in their preparation to provide services to those Latino/a who are dominant in Spanish. Their familiarity with the language, including colloquial language and *modismos*, or expressions, positions them well for the varied conversations they will have in clinical settings. Second, a cultural match may provide Latino/as seeking mental health services with a degree of comfort and familiarity that could ease what may be a stressful initial process. While not all Latino/as, of course, are fluent in Spanish, and clinicians of other

racial backgrounds may be fluent in Spanish, qualified Spanish-speaking Latino/a clinicians are an obvious resource for serving the Spanish-speaking population.

The English-Only Movement in Relation to Spanish Language Care

An important contextual factor to consider in an examination of the availability and accessibility of Spanish language mental health services is a societal-level bias towards English language exclusivity, exemplified by the “English-only” movement. This is a movement organized with the intent of making English the official language of the U.S., and restricting use of other languages in a variety of public settings. Critics of the English-only movement, such as Padilla et al. (1991), suggest that the movement is rooted in a racist, anti-immigrant ideology that is particularly virulent towards Spanish-speaking immigrants. For example, in 1986, John Tanton, chair of the leading English-only organization U.S. English, issued a memo in which he accused the Spanish-speaking immigrant population of posing a range of cultural threats, including,

...the tradition of ‘la mordida’ (bribe), the lack of involvement in public affairs, Roman Catholicism, with its potential to ‘pitch out the separation of church and state’, low “educability” and high school dropout rates, failure to use birth control, limited concern for the environment, and, of course, language divisions (Crawford, 1989, p.57).

These sentiments negatively impact both the delivery of mental health services to individuals with limited English proficiency, and the psychological health of these same individuals. In settings where English-only sentiment holds influence, Spanish language services may not be offered, prioritized, or of high quality. Individuals with less fluency in English may be shamed for their language skills and/or coerced into receiving services in English. In an editorial on the English-only movement’s impact on mental health services, Comas-Diaz and Padilla (1992) note that the English-only movement sends

individuals with limited English proficiency a message that cultural and linguistic diversity is not tolerated, which can negatively affect identity and self-esteem, and may result in feelings of insecurity, self-hatred, depression, and other mental health problems.

In contrast to the tenets of the English-only movement, which often characterize immigrants as resistant to learning English, research indicates that linguistic assimilation occurs among all immigrant populations, including with the great majority of Latino/a immigrants, within one or two generations. In fact, languages other than English are most threatened in the United States; without the replenishing effects of immigrations, most other languages would gradually fade (Veltman, 1988). Also, a large majority of Latino/a immigrants are strongly in favor of having English be taught to their children. In a survey of over 3,000 racially diverse adults, 92% of Latino/as said that the goal of teaching English to the children of immigrant families is "very important", while only 2% stated that this goal is "not important" (PEW Hispanic Center, 2004). Latino/a survey participants actually named this goal as important in greater numbers than did White participants. These findings indicate that learning English is a shared goal. It is the preservation and use of the Spanish language that is truly the point of contestation between English-only advocates and Spanish speakers. In the context of increasing numbers of Spanish speakers immigrating to the United States, this bias against use of the Spanish language presents a huge barrier for Spanish speakers in accessing all of the services that they need, including mental health services.

Best Practices for Spanish-Dominant Clients

When Latino/a clients who communicate most proficiently in Spanish do present for mental health services, a review of the existing literature indicates that these clients,

including those with moderate proficiency in English, benefit from accessing services in Spanish. In the article, “Effects of language usage on the emotional experience of Spanish-English and English-Spanish bilinguals” (Gutfreund, 1990), the researcher studies how language impacts access to emotional content. Spanish-dominant bilingual participants, among other groups, completed an exercise designed to induce an emotional reaction. The researcher found that bilingual, Spanish-dominant participants express more affect in Spanish. He reasons, then, that therapy for Spanish-dominant clients may be far more meaningful when it is conducted in Spanish, because these clients will be more able to access and express their feelings in their native language. Expression of affect is also very important to psychiatric diagnosis and suicide assessment, in that it may impact evaluation of the severity and nature of symptom presentation. Given these findings, Gutfreund concludes that therapy with clients who are dominant in Spanish should always be conducted in Spanish.

Research indicates that language difference may not only impact the quality and depth of the therapy experience, but may actually yield different diagnostic results (Malgady & Costantino, 1998). In a study of first generation Spanish-dominant adult Puerto Rican and Dominican American patients, Malgady found that diagnostic severity was highest in bilingual and Spanish language interviews, and lowest in English language interviews. Malgady concludes that a higher severity of symptoms when the patient is interviewed in Spanish may be attributed to the patient feeling more comfortable sharing more information and more symptoms. When the patient is struggling with a language barrier, however, the patient may tend to be more guarded, uncooperative, and reluctant to communicate. Also, language-induced symptoms may present when patient is

communicating in a second language, as opposed to actual pathological symptoms. For example, anxious symptoms may arise due to discomfort with language problems.

Marian and Neisser (2007) confirm the conclusion that language of treatment impacts content and quality of care in a study of Russian-English bilinguals. In the study, the participants were asked to recall life memories based on word prompts. Some interviews were conducted in English, and some in Russian. The researchers found that participants retrieved more experiences from Russian-speaking life periods when they are interviewed in Russian, and more experiences from English-speaking life periods when they are interviewed in English. From these results, the researchers concluded that events occur within a "linguistic ambiance". That ambiance can be recalled through the use of the language, affecting mood and access to memory. According to these authors, "autobiographical memory is saturated with language" (p.366). This article leads us towards a more nuanced understanding of how language in a clinical encounter for a bilingual client may impact the content of the therapy. It may not be that therapy must always be conducted in the client's native language. For example, for a client who learned Spanish as her first language and then English as a student, memories of early childhood may best be retrieved in Spanish, while memories of university may best be retrieved in English. These conclusions indicate that bilingual therapy may in fact be preferable to therapy exclusively in the client's native or dominant language. In bilingual therapy, language switching (using different languages for different portions of a session or different sessions), and language mixing (using different languages in close proximity to each other), are used to produce a fuller therapy experience where the bilingual client can experience multiple aspects of his or her multilayered self.

Some research has explored the use of interpretation services as a possibility for expanding access to care for Spanish-dominant clients, without relying on the training of clinicians in languages other than English. Interpretation services offer an option for providing services where otherwise they may not be offered, especially in geographic areas or languages where it is difficult to hire a bilingual clinician. In addition, numerous studies inform the provision of more culturally competent, effective interpretation in clinical settings. However, the body of literature indicates that receiving therapy through interpretation results in lower-quality care in comparison to receiving services directly from a bilingual clinician. According to the article "Translation in Bilingual Psychotherapy", numerous challenges present themselves in therapy using an interpreter that can potentially have negative impact on the quality of the psychotherapy service (Bradford & Muñoz, 1993). For example, figures of speech are often crucial, emotionally laden phrases in therapeutic encounters. However, they can be difficult to interpret, as their literal interpretation may not communicate the full meaning of a culturally specific phrase, while their figurative interpretation may not be accurate to the client's original meaning. Also, mental illness can affect language in a number of ways that may be difficult for an interpreter to communicate. A client with a thought disorder or experiencing a manic episode may have bizarre ideas, loose associations, or incongruous sentences. Negative symptoms may result in a restriction in the breadth of the client's usual lexicon. An interpreter often tends to mediate the difficulty of translating these phrases by altering them into something more coherent, which may result in the clinician not fully understanding the severity of the client's communication difficulties. If these challenges are managed well, therapy through interpretation may be

adequate. Even if all these challenges are successfully managed, however, Bardford and Muñoz conclude that therapy through an interpreter is a less optimal alternative to therapy with a fully bilingual clinician.

A study on interpretation in psychotherapy with a refugee population (Miller, Martell, Pazdirck, Caruth, & Lopez, 2005) finds further challenges to providing therapy through an interpreter. The researchers find that the relationship between therapist and client tends to form more slowly with the use of an interpreter. The client's initial attachment is often to the interpreter, since it is the interpreter who the client understands, and also, because the interpreter and the client are likely to share a similar cultural background. The researchers advise that the clinician who uses an interpreter should be patient with the relationship development, and allow the attachment to grow gradually, since if properly nurtured, the relationship between the client and the interpreter can serve as a bridge to the relationship between the client and the clinician. These researchers' findings have potential implications for how the adequacy of clinical services provided with the use of an interpreter may be associated with length of treatment. It may be that interpreters may be used effectively in longer-term treatment, where the attachments between client, interpreter, and clinician have time to develop, while they are less effective in shorter-term treatment, where the slower pace of attachment between client and clinician may impede the rate of therapeutic growth. However, this study assumes the presence of one interpreter who is consistently assigned to a particular case. When, as in many settings, interpretation services are provided by a different professional each session, there may be insufficient time for attachment to grow between any of the parties, presenting a real challenge for treatment.

Vasquez and Javier (1991) add to Bradford and Munoz's exploration of the challenges that interpreters face by outlining basic errors that interpreters are likely to make, given the challenges of interpretation. They describe five basic errors: omission, where the interpreter fails to relay some portion of the client's statement; addition, where the interpreter adds additional material to the client's statement; condensation, where the interpreter simplifies or attempts to explain the client's speech; substitution, where the interpreter replaces some portion of the client's statement with other material; and role exchange, where the interpreter replaces the clinician's questions or statements with his own. The researchers describe two case examples where a combination of these errors results in an incorrect clinical judgment. In one case, the interpreter adds information to the client's disclosure of passive suicidal ideation that leads the clinician to believe that the client is actively suicidal, and to take unnecessary protective action. In another case, the interpreter condenses the client's statement of suicidal intent in a way that minimizes such intent. The client is released into the community and then re-admitted to the psychiatric center within a week due to a suicide attempt. These case examples show how risky the basic errors that these researchers call attention to may be; interpretation errors may contribute to client danger or even suicide. Ostensibly, the risk of these disastrous misinterpretations could be avoided if direct services from a bilingual clinician could be offered.

Opportunities and Challenges in Cross-Cultural, Cross-Linguistic Relationships

While considerable evidence indicates that mental health care for Spanish-dominant clients should be in Spanish, and is best done directly rather than with the use of an interpreter, less research has explored the possibility of White clinicians providing

these services. However, given large numbers of Spanish-dominant clients presenting for services, and too few qualified Latino/a Spanish-language providers to meet their needs, it makes sense to consider how White clinicians might help to fill this gap. While little existing literature centers specifically on the dyad of the White clinician and the Latino/a Spanish-speaking client, some literature does exist to inform how we conceptualize this possibility. One researcher found that a therapeutic relationship between a clinician of the dominant culture and an immigrant client might actually yield certain therapeutic benefits. Kitron (1992) uses case examples from his own experience as a White, Israeli therapist conducting therapy in French with immigrants from French-speaking countries to highlight potential benefits of a therapist from the dominant culture providing services to an immigrant in the language of the immigrant's country of origin. Kitron finds two major thematic benefits in his representative cases. First, because the client has full mastery of his or her native language, and the therapist does not, the client experiences increased power in the relationship, which is important for the client's self-esteem and empathy-building in the dyad. The second potential benefit is that the therapist who speaks the client's "mother tongue" but is native to his or her new country may serve as a transitional object for the client, as the therapist's connection both to country of origin and country of current residence may help the client bridge the emotional gap between these two places. Kitron suggests that these advantages may help explain the preference of many immigrant clients for native-born therapists, as an immigrant therapist may be perceived as too like the client, or too weak, while the native-born therapist may be idealized. This article is helpful in pointing to unique aspects of the relationship between an immigrant client and a clinician of the dominant culture, which may, under some

circumstances, be beneficial in treatment. What is missing in Kitron's study, though, is an analysis of the social systems that contribute to the idealization of the native-born therapist and the devaluing of the immigrant therapist. When an immigrant client views an immigrant therapist as weak, and prefers not to see this therapist, projection of the client's internalized racism and shame around his or her immigration status is very likely involved. A more culturally informed treatment plan in an impasse between an immigrant client and an immigrant therapist would be to work through that defense, and to help the immigrant reconstruct a more positive view both of him/herself and of the therapist, rather than colluding with the client's idealization of a native-born therapist by transferring the client to such a therapist. Kitron's study is an example of how a bilingual therapist's work can be idealized, and not subjected to close enough analysis of how his or her perceived "success" is exaggerated due to oppressive social constructs.

While Kitron (1992) enumerates potential benefits of a clinician from the dominant culture providing services to a client of a subordinate culture, a greater body of literature points to the challenges and potential limitations of such therapeutic relationships. Cultural difference can pose challenges to a therapeutic relationship, and linguistic difference can be conceptualized as an additional layer of challenge. According to one researcher, (Isaac, 2001, p.110), "If cross-cultural interactions run the risk of miscommunication, then cross-linguistic interactions will run a greater risk of breakdown because they inevitably involve different cultures as well as different languages". These layers of difference and potential for breakdown suggest the need for in-depth analysis of the challenges around cross-cultural, cross-linguistic service provision, and how these challenges might best be negotiated.

In the article, “Exploring dimensions of culturally sensitive clinical styles with Latinos” (Lu, Organista, Manzo, Wong, & Phung, 2001), the researchers examined how Latino/a and White clinicians compare in their clinical styles, and how this impacts the ways in which they conceptualize and treat cases involving Latino/a clients. The researchers found statistically significant differences between clinical styles and decision-making between Latino/a and White clinicians. The Latino/a clinician group displayed higher levels of cultural competence, with a more exploratory stance and more culturally relevant interpretations, while the White, non-Latino/a clinicians offered interpretations that were not as culturally relevant and were more directive. Given these factors, the researchers determined that Latino/a clinicians tend to provide more culturally sensitive care to Latino/a clients than do White clinicians. The results of this study indicate that differences in treatment of Latino/a clients by White and Latino/a clinicians are rooted in different relational styles, which are shaped by the clinicians’ cultural selves. The results indicate not only that cultural matching may be useful, but also, that White clinicians in cross-cultural clinical relationships can improve their service provision by increasing their awareness of their clinical style, and when appropriate, modifying their style to more closely match that of Latino/a clinicians.

Amato (2007) further explores how White clinicians' success in treating Latino/a clients may be impacted by their reflexivity around their cultural identity and clinical style. In her thesis, Amato interviewed White therapists who provide services to Latino/a clients. About half of the participants provide services in Spanish. Amato found that a significant majority of clinicians in her sample had poor levels of cross-cultural competency, and were uncommitted to improving their skills in this area. Clinicians often

claimed that cultural differences did not affect the therapeutic relationship in any way. They display a lack of basic knowledge about Latino/a cultures and poor cross-cultural competency. Given these results, the researcher concludes that White clinicians who engage in cross-cultural work with Latino/as need to be offered and to pursue training to improve their skills, and importantly, to become more aware of their own biases and of the significance of cultural differences in the therapeutic relationship. This study represents an important contribution to the literature because it points to a disparity between White clinicians' assessment of their levels of cultural competence, and their actual levels of competence. However, because Amato does not compare responses from participants who speak Spanish versus those who don't, she misses an opportunity to examine the relationship between Spanish language skills and cultural competency.

Sue, Fujino, Hu, Takeuchi, and Zane (1991) further the base of knowledge around clinician matches for Latino/a clients with a study of community mental health centers in Los Angeles. These researchers found that an ethnic match resulted in a longer length of treatment for Mexican Americans and better client response to treatment. Mexican American clients were found to prematurely drop out of treatment more frequently with a non-Latino/a clinician than with a Latino/a clinician. In addition, treatment outcome, as measured by change in a global assessment of functioning score before and after treatment, was found to be positively associated with cultural matching for Mexican American clients. Again, Mexican American clients assigned to Latino/a clinicians were found to have the best treatment outcomes. When the researchers specifically considered the impact of ethnic matching for study participants for whom English was not their primary language, they found that an ethnic match had an even higher association with

fewer premature dropouts, a higher total number of sessions, and improved outcomes. Of these findings, the researchers explain, “Clients who do not speak English as the primary language are likely to be immigrants and less acculturated, and the benefits of the match may be more apparent” (p.539). Thus, this study suggests that the best practices in providing care for Spanish-speaking clients would be to provide, when possible, a culturally matched clinician. A limitation to this study, however, is that it does not consider how limitations in non culturally matched providers’ fluency in the clients’ language may impact the course and outcome of treatment, and whether increased fluency might yield better outcomes.

Addressing Challenges in Cross-Cultural, Cross-Linguistic Relationships

The research reviewed thus far has indicated that Spanish-language services are preferable for Spanish-dominant clients, and are ideally provided by clinicians with Spanish-language skills. While one researcher found some potential benefits in cross-linguistic, cross-cultural work, most researchers view this work as challenging and potentially limiting to the quality of care. This review of literature now turns to the work of researchers who recognize the challenges that arise in cross-cultural, cross-linguistic work, and have recommendations for what clinicians can do to address these challenges. One researcher (Clauss, 1998), recommends that White therapists who speak Spanish carefully examine their linguistic countertransference, which refers to the feelings that emerge from the clinician’s Spanish language learning and interaction with Spanish speakers. Whether the clinician learned Spanish in an academically rigorous and sometimes overwhelming college setting, on an extended trip volunteering in Guatemala, or in conversation with a former or current partner, the clinician is likely to have complex

feelings around his or her Spanish language skills. By examining one's own feelings around Spanish language, the clinician is more freed up to use Spanish language in the ways in which the client needs the language to be used. According to the researcher, "...our role as therapists is to be conversant in the particular language within which our patients experience their world" (p.188). This means that the therapist will need to shift between Spanish, English, or some combination of the two, at the client's will, and also to explore what these language shifts mean to the client. Language can help the client release more emotionally charged material, and can create distance from the material through defensive maneuvering. The White therapist, in particular, will also need to be mindful that his or her disclosure of Spanish-language fluency may be a significant moment in therapy and bring up a range of feelings from the client. For example, Clauss has found that many patients become confused when they learn that he speaks Spanish, and manage the ambiguity by assuming that Clauss is of Spanish origin, which he is not. He advises that the clinician should be intentional around the timing of this disclosure and again, facilitate processing of its meaning in the relationship.

Another researcher recommends the use of particular ideas that are located in the Spanish language and Latino/a cultures as a point of joining between clinician and Latino/a client. In the article, "'Dichos' as metaphorical tools for resistant Latino clients" (1991), Zuniga encourages the use of *dichos*, or proverbs from Latin American culture, to locate therapeutic recommendations in a Latino/a cultural context. She suggests that the use of *dichos* may make therapeutic recommendations more relevant for the client, and increase client compliance with services. The researcher reports success with the use of *dichos* in her therapeutic interventions, and states that their usage "helps reframe the

problem, conflict, or situation within a Mexican cultural perspective” (Zuniga, p.481).

Zuniga encourages even clinicians who are not fluent in Spanish to use these *dichos* in consultation with native Spanish-speaking clinicians. She states,

In consultation with Latino therapists knowledgeable of *dichos*, non-Spanish-speaking therapists can demonstrate their acknowledgement of the importance of culture by inserting *dichos* that make critical points and would not be misinterpreted as disrespectful. Moreover, since the *dichos* are so brief, the non-Spanish-speaking clinician can learn to pronounce them in Spanish. Asking their client to help them with their pronunciation is another way to show respect for the client's culture and to enhance the client/worker relationship.” (p.482)

Zuniga, a Latina woman who is fluent in both English and Spanish, relays valuable information on the success of the use of *dichos* in her own practice. However, she makes an untested assumption in generalizing that her successes with this technique will predict the success of other practitioners, including those who do not speak Spanish. This article is important because it has to do with the “edge” of what clinicians whose first language is not Spanish can provide for Latino/a clients. Clinicians who are not fully fluent in Spanish language and, importantly, knowledgeable about Latino/a culture, may have difficulty integrating the use of these *dichos* in a culturally sensitive way, even with the use of consultation. Her recommendation holds a danger of encouraging clinicians who have no background in Spanish language to use proverbs as tokenistic indicators of cultural competency to convince “resistant” clients that the therapist can “speak their language.” This speaks to the way in which minimal Spanish-language skills are used, sometimes superficially, as an indicator of cultural competency for non-Latino/a clinicians working with Latino/a populations. It also speaks to a larger problem of clients being labeled as “resistant” when they exhibit behaviors that let the clinician know that the services are not meeting their needs, as in the case of a Spanish-dominant client who

"resists" English-language therapy until the treating clinician makes an effort to meet the client in their language. These "resistances" are actually important communications that the client is making as an agent in his or her own care. While Zuniga's recommendation that *dichos* can contribute to joining between clinicians and Spanish-speaking clients is well-received, more inquiry is needed to understand how non-Latino/a clinicians, in particular, can integrate the use of *dichos* in a culturally competent way.

Clauss, a bilingual (English/Spanish) White clinician, offers a recommendation related to Zuniga's as to how a monolingual English-speaking clinician can make connection with a Spanish-dominant Latino/a client through the use of language (1998). He suggests that the clinician can allow the client to disclose and free associate in their native language, and then provide a brief translation for the therapist. Again, it seems absent from this analysis that information is lost when the client speaks and the therapist does not understand. Time is also lost; it is unfair to the client to require that he or she use the therapy hour to translate her thoughts for her therapist. If it is determined that a client will benefit from having Spanish incorporated into the therapeutic process, it is only fair that a bilingual provider or an interpreter is provided.

Castaño, Biever, Gonzalez, and Anderson (2007) further elucidate the challenges for Spanish language providers by pointing out how, even for Latino/as who learned Spanish as their first language, conversational fluency does not readily translate to clinical proficiency in Spanish, in spite of many agency administrators' assumptions. In their study of 127 clinicians, 95% of whom were conversationally fluent in Spanish, more than half of the respondents reported concerns regarding their application of psychological concepts and theories in Spanish. Since English was the language of a

large majority of these clinicians' training, English was the language in which many clinicians felt most comfortable providing clinical services. The researchers suggest that for bilingual Latino/a service providers, there may be a dual sense of self. The clinician's personal sense of self as a member of the Latino/a community may be split off from the clinician's professional sense of self; Spanish may be connected with the clinician's personal identity and English with the clinician's professional identity. When Latino/a clinicians in this study were asked for their suggestions for training, they most frequently requested Spanish language supervision and opportunities for cultural and language immersion. The researchers also highlighted the importance of informal means to increase language proficiency, like reading and watching television in Spanish and socializing in Spanish. Many of the dynamics and suggestions for training that are here applied to a mostly Latino bilingual clinician population can also be applied to a White bilingual population. White clinicians in the U.S. are also trained almost exclusively in English, and may experience a split between themselves as Spanish speakers in certain contexts and themselves as English speakers in their professional lives. White and Latino/a Spanish speakers alike face the challenge of translating most or all of their clinical training from English to Spanish, and may experience discomfort in using their Spanish language skills professionally.

Training, Evaluation, and Support in Cross-Cultural, Cross-Linguistic Service Provision

In order for clinicians to adequately serve the needs of Spanish-dominant clients, clinicians need comprehensive Spanish-language clinical training opportunities. Two different training models for increasing linguistic cultural competency for clinicians providing services to Latino/a clients are presenting in the literature. In the article, “The

Role of Language in Training Psychologists to Work with Hispanic Clients” (Biever, Castaño, de las Fuentes, González, Servín-López, Sprowls, & Tripp, 2002), researchers test the efficacy for one existing model for a clinical training program based at Our Lady of the Lake University in Texas designed specifically to improve bilingual clinicians’ readiness to provide Spanish-language services to Latino/a clients. A second article reviews an educational program located at Richard Stockton College of New Jersey, with similar goals of training social workers to practice in the Spanish language (Cox, Falk, & Colón, 2006). Both articles are written by faculty and staff members of their respective programs, and are evaluated through an analysis of student evaluations, with one study also using focus groups and participant observation. The programs are similar in that they provide classroom study, fieldwork, and an option of traveling abroad for a cultural immersion experience. Both studies yield similar positive program evaluations, and assert that these programs improve skills that include ability to think theoretically in Spanish, increased confidence in Spanish language skills, knowledge about Latino/a cultures, and cross-cultural self-knowledge. Due to positive responses of students to this training program, both researcher teams conclude that these programs provide an important means of improving quality of care for Latino/a clients, and recommend the development of other similar programs. The programs offer hopeful models for what an effective Spanish language clinical training model might look like. However, since both articles are written by faculty internal to their particular programs, and use a qualitative approach, no information is available to allow for a quantitative assessment of which program, or which aspects of each program, objectively provides the best training. As more of these types of programs are developed, comparison between various programs will become

increasingly important, so that programs can borrow from each other's best assets, and the national standard for such programs can improve.

A final step to empowering White clinicians to provide high-quality services to Spanish-dominant clients is in the support and supervision that they receive from their agencies of employment. In their article "Assessing Language Competence: Guidelines for Assisting Persons with Limited English Proficiency" (Acevedo, Reyes, Annett, & López, 2003), the researchers call for agencies to take more responsibility in creating adequately high standards for Spanish language competence in hiring clinicians to provide Spanish language services. They express concern with the lack of universal criteria with which to assess clinicians' language competencies. They offer a comprehensive model for testing the language competence of clinicians and interpreters, which includes verbal comprehension, reading comprehension, writing, and speaking. They also offer a set of guidelines for providing culturally competent services to clients who are dominant in languages other than English. This article breaches the important topic of ethical issues around hiring clinicians to provide services in languages in which they are not fully fluent. Still, it omits the larger systemic issue of there being not enough bilingual clinicians available to meet the needs of the clients dominant in languages other than English who seek services. It creates criteria for excluding clinicians who are not fully bilingual from providing services, but it does not provide alternatives for replacing the services provided by these now-excluded clinicians, other than interpretation, which, as the researchers state, carries its own set of problems.

Fuertes (2004) provides recommendations as to how supervisors can most successfully support their bilingual supervisees. This article applies to bilingual

supervisees of any cultural and racial background. According to Fuertes, supervisors must assess the language preference of supervisee. This language preference assessment is similar to a language preference assessment that should be done for bilingual clients. However, in contrast to therapy, the most effective language for supervision may not be the supervisee's native language or the one in which he or she feels most fluent. The supervisee and supervisor may be able to stay closest to the events, experiences, and affect of the therapy by processing it in the language of the therapy. When language is switched or mixed during the course of the therapy, these shifts should be examined for meaning. Fuertes adds that supervisors should feel comfortable addressing personal and countertransference issues of language, race, and culture, which may be relevant to establishing rapport or other tasks of supervision. She also speaks to cultural and acculturation difference between the supervisor, supervisee, and client, who she sees as involved in one relational construct. She notes that, ideally, the supervisor should be most acculturated, then the supervisee, and then the client; changes in this structure can lead to conflict in values, expectations, and goals. The nature of this expected conflict is unclear, and this specific recommendation seems suspect, as if both therapy and supervision were lessons in acculturation. Her statement also assumes that therapist, supervisee, and client are all of the same cultural background, which is not the case even if all three are bilingual in the same languages. Further inquiry is needed into how the relationship between bilingual supervisor, supervisee, and client is developed and challenged when all three parties are not of the same cultural background, or when levels of acculturation do not progressively increase from client to supervisor.

Summary

In sum, most researchers concur that clinical services are best provided in the language in which the client is dominant, by a clinician that is also dominant in that language. High-quality service provision in the client's dominant language, by a clinician who has acquired skills in that language but is dominant in another is generally thought to be possible, but carries with it numerous challenges. Clinicians, training programs, and agencies have significant control over how these challenges impact quality of care, in the preparation, support, self-knowledge, and cultural competence of the clinician.

While this body of literature provides a framework for understanding dynamics around White clinicians' provision of care for Latino/a clients, gaps in the research persist. While on a systemic level, we understand that there is a demand for Spanish-speaking therapists in the field, we don't have a good understanding for why individual White clinicians choose to provide services in Spanish, what appeals to them about this work, and how they navigate the work's complexities. How do clinicians engaging in this work view potential benefits versus challenges of cross-cultural, cross-linguistic work? From clinicians' perspective, what training and support has been most helpful in improving their Spanish language service provision? Because no published study has been located that specifically reviews the provision of Spanish language services by White, English-dominant clinicians, many questions remain as to how clinicians actually think and feel about providing these services. Therefore, this study uses a qualitative, exploratory approach to document and explore White clinicians' motivations, experiences, and challenges in providing Spanish language services.

CHAPTER III

METHODOLOGY

The research question that this study seeks to answer is: What are the motivations and experiences of White social workers and psychologists who choose to provide services in Spanish to Latino/a clients, and what do they perceive as the challenges involved in providing these services? The clinicians' ideas around what types of training and support would best position them to address these challenges are also be explored.

Research Design and Recruitment

This research question is answered through flexible-design, exploratory interviews with thirteen participants who are social workers or psychologists in the state of California. Participants were gathered by a non-random sample of convenience and snowballing through networking with personal and professional acquaintances. To qualify for participation in this study, participants were required to be White, English-dominant, coordinate English/Spanish bilingual social workers or psychologists who have conducted clinical work in Spanish with Latino/a clients after the receipt of a Master's or Doctorate Degree in Social Work or Psychology. Because this study focuses on dynamics particular to Spanish language service provision by those in the dominant culture, interview participants were limited to those who identify as White or Caucasian. However, the researcher sought diversity in sex, experience, Spanish language fluency, and nature of professional work by networking with acquaintances from a variety of sources. *Coordinate bilinguals* are individuals who learned two languages in different

contexts or at different times in their life. For the purposes of this study, the researcher limited participation to individuals who learned English as their first language and learned Spanish after age 5. The definition of “White”, for the purposes of this study, includes clinicians who self-identify as White or Caucasian, and do not identify as Latino/a. The sample was limited to clinicians currently residing in and providing services in the state of California.

Upon identifying a referral for a potential participant, the researcher telephoned or emailed the participant, briefly explained the purpose of the study, and asked whether the individual would consider participation. If so, the researcher screened the potential participant for eligibility. If the potential participant was deemed appropriate and willing, the researcher and participant arranged to meet at a location of the participant’s choice, and the researcher provided the participant with an electronic copy of the Informed Consent by email in advance of the interview. At the interview’s start, the researcher presented the participant with a paper copy of the Informed Consent. The researcher verbally stated the purpose of the informed consent form, and asked the participant to review the written form and sign it if he or she was in agreement. The participant was given a copy of the informed consent form for his or her own records. Participation in this study was voluntary. Participants were able to withdraw from the study at any time during the data collection process and were able to decline to answer any question without penalty.

Data Collection

All interviews were conducted in English, with Spanish words or phrases used at the participant's discretion. The interviews began with a set of short-answer questions to

collect background information around the clinicians' age, gender, race, ethnicity, and level of competency in Spanish. Information pertaining to the context of the clinician's Spanish-language education and clinical training were also sought, along with information as to how often, and with what training and support, the clinician provides Spanish-language services. The body of the interviews was informed by a set of guiding questions. First, each participant was invited to reflect upon what it means to be a White person who speaks Spanish, and what motivated the participant to provide services in Spanish. Then, the interview explored experiences, successes and challenges that each participant encountered in providing Spanish-language services. Perceptions of the White Spanish-speaking clinician, including those held by his or her clients, colleagues, and supervisor, were explored. Each participant was then asked to reflect upon treatment decisions in Spanish-language care, including referral decisions. Each participant was asked to evaluate the quality of care that he or she is able to provide in Spanish versus in English. Finally, the participant's thoughts on training or support that could help improve the quality of the Spanish-language services he or she provides were solicited.

After data were collected, interviews were coded and identifying information was removed. All data, including electronic data, were securely stored. All data and tapes are to be kept secure for three years, as required by Federal regulations. After that time, they will be destroyed when the data are no longer needed.

Bias

Sources of potential bias in this research include this researcher's identification as a White social work trainee who has provided Spanish language social work services in a variety of settings. This identification aligns the researcher with the study participants.

The researcher also brings pre-formulated opinions on the value of this work, and on its challenges, based on her experiences. This researcher feels invested both in the training and recruitment of more Latino/a clinicians, and in the potential for non-Latino/a clinicians, with proper training and support, to provide high-quality Spanish language services. This researcher is committed to providing culturally competent services, and working against systems of Racism, White Privilege, and English Hegemony, and holds the bias that these should be priorities for all clinicians who engage in cross-cultural work. For the purposes of this study, this could lead the researcher towards valuing responses that reflect a similar commitment to or curiosity about the impact of these systems of oppression, and being more dismissive or critical of responses that minimize the impact of these systems. Finally, this researcher holds a belief that mental health services offered Spanish-speaking clients as a whole should be vastly improved, and a hope that this is possible, potentially minimizing the real challenges of this transformation.

Sample

The thirteen research participants interviewed here range in age from 28 to 73, with a mean age of 44 years old. Ten participants identify as female and three identify as male. In terms of race, eight participants identify as Caucasian or White, and four as Caucasian or White and Jewish. In terms of ethnicity, six participants identify as Jewish, with one specifying Ashkenazi Jewish; three identify as Caucasian or White; two as mixed European; one as Jewish, Irish, and English; and one as Danish-American. Participants provide services in at least six different cities in both Northern and Southern

California. A few participants provide services in more rural areas, while most work in urban centers.

Participants were asked to rate their level of Spanish language proficiency according to N. Patrizio-Quñones's Classification of Language Proficiency Scale (as cited in Biever et al., 2002, p. 334). Four participants rated their proficiency at a level of 3.5 out of 5, with Level 3 indicating ability to hypothesize, express and defend opinions, and handle unfamiliar situations, and Level 4 indicating an ability to persuade, negotiate, counsel, and represent a point of view. Six Participants rated themselves at Level 4. Two participants rated themselves at a level of 4.5, and one participant rated himself at Level 5, with Level 5 representing skills equivalent to an educated native Spanish speaker. For the purposes of discussion, the researcher grouped the participants according to self-described level of language proficiency. Those participants who rated themselves at Level 3.5 (participants One, Seven, Ten, and Eleven) are considered less fluent. Those participants who rated themselves at Level 4.5 or 5 (participants Two, Three, and Four) are considered more fluent. Those participants who rated themselves at Level 4 (participants Five, Six, Eight, Nine, Twelve, and Thirteen) are considered intermediately fluent.

When asked where and when they learned Spanish, participants reported a wide variety of sources of learning, with most participants listing several or many sources. All participants had done some language learning abroad and some domestically. In addition to the United States, the most common locations where participants learned Spanish included Spain (four participants), Mexico (four participants), Guatemala (three participants), and El Salvador, Costa Rica, and Chile (two participants each). Eight

mentioned studying Spanish in Junior High School or in High School. Nine studied in college, with four participants spending a year abroad in Spain and one spending a year abroad in Chile. One studied abroad briefly while in graduate school. One participant received private Spanish language tutoring domestically, and another took Spanish language classes. Two developed their Spanish language skills by volunteering internationally, and two developed their skills by volunteering domestically. Two developed their skills with pre-degree paid work internationally, and two with pre-degree paid work domestically. Several mentioned that their Spanish language skills improved significantly in their post-degree clinical work. Five specifically mentioned travel as a learning opportunity. One mentioned hearing Spanish in the home in her family of origin, and at least four use or have used Spanish in the home with their partners as adults.

In terms of educational background, nine of the participants hold Masters in Social Work degrees, one holds a PsyD, and two hold PhD degrees in Psychology. One participant holds three clinical degrees: a Masters in Marriage Counseling, a Masters in Substance Abuse Counseling and General Psychology, and a Masters in Social Work. The participants received their degrees from seven different training programs, five of which are located in California. Participants with a range of experience in providing services in Spanish were interviewed. At the time of their interview, participants had provided Spanish language services for a length of between five weeks and 27 years, with an average length of experience of about 9.5 years. At the time of their interview, participants were providing Spanish language services, meaning that they spoke in Spanish to the client or to at least one key player in the case (i.e. a parent or guardian), to

between five percent and 100 percent of their total cases. On average, participants used Spanish in about 45% of their cases. Several participants noted that they had provided more Spanish language services earlier in their careers, and now worked less in Spanish as they moved into supervisory positions, more specialized service provision, or private practice work. Participants work in a range of settings, including but not limited to community mental health clinics, medical clinics, psychiatric health care facilities, hospitals, and schools. Eight providers work with children and/or families, three work with mixed age groups, and two work with adults.

Participants were asked about any specific training that they received from their clinical training programs, agencies of employment, or other sources, specific to providing Spanish language clinical services. Most participants indicated that they had received little formal training in this regard. One participant participated in an *intercambio*, or exchange program, as part of her clinical training. Several others had internship experiences in which they provided services in Spanish and received supervision particular to these skills. Some participants received brief trainings on cultural competence, language skills, or bilingual service provision through their agencies of employment. One participant had a one-month learning trip abroad subsidized by her agency of employment. However, for most participants, the bulk of their Spanish language learning, and learning to provide clinical services in Spanish, had occurred through opportunities that they pursued independently of their clinical training and employment. In addition, many participants became much more proficient at both speaking Spanish and providing services in the Spanish as they used these skills on the job.

CHAPTER IV

FINDINGS

The findings of this study indicate that the White, Spanish-speaking social workers and psychologists interviewed here have personal, professional, and political motivations for providing services in Spanish. They tend to experience their identities as inviting both opportunity and challenge. While on the one hand, they are able to connect with monolingual Spanish speakers, engage in rewarding and needed work, and may enjoy an advantage in their careers, on the other, they face unique linguistic and cultural challenges. The challenges that providers face are varied, and while some are felt most intensely early in providers' careers, others continue to present even for clinicians who are very experienced in this type of work. Participants noticed that their Spanish-speaking clients tend to respond to them warmly, and to be accommodating and gracious around any limitations in the clinicians' Spanish language skills. Still, participants observed and/or imagined that Spanish-speaking clients relate to Latino/a providers with more familiarity and ease, and participants did not generally see their Whiteness as an advantage, except under particular conditions. Rarely did participants refer a Spanish-speaking clients to a native Spanish speaker, due both to access and to clinical preference, although many wish that they could under certain conditions. Participants reported that they were appreciated and valued by non-Latino/a colleagues and supervisors, and encouraged and mentored by Latino/a colleagues and supervisors as a whole. However, a

significant population did report rare instances of discord between themselves and Latino/a colleagues having to do with language and/or culture. When it came to considering the quality of the Spanish language services that they were able to provide, most providers indicated that they were at least slightly less skilled in providing services in Spanish as compared to English. However, clinicians who were more fluent in Spanish were more likely to indicate that they still felt able to provide high-quality services, while less fluent clinicians were more concerned about whether they were truly able to provide adequate services. Finally, participants generally felt that much of their learning to provide Spanish language clinical services has come through their own initiative and through informal support, and suggested many ways in which they might continue to improve their skills, and ways in which their clinical training programs and/or agencies of employment could be more supportive to them in their skill development.

Another major finding of this study is that there appear to be some significant differences between the experiences of clinicians who speak Spanish more fluently and those who speak Spanish less fluently. More fluent participants felt more at ease with their Spanish language skills, more at ease with and in Latino/a communities, and while most still acknowledged challenges to cross-linguistic work and limitations in their skills at providing services in Spanish, they were more at ease with these challenges and limitations, and more confident that they were still able to do this work well. Conversely, less fluent participants felt more anxious and inadequate about their Spanish language skills, often had less incorporation of Latino/a cultures in their personal lives, and were less confident in their abilities to do the work well. Lessons may be learned from both ends of the spectrum. For more fluent providers, their commitment to incorporating

Spanish and connection with Latino/a communities as a significant, and often central, part of their personal lives, coincided with them gaining a lot of confidence in their ability to work in Spanish professionally. Their love for Spanish and Latino/a communities served them well professionally and enriched their personal lives. This integration of the personal and the professional connection to Spanish language and Latino/a communities seems to be a key component of what enables Spanish-speaking White clinicians to feel successful in their work. On the other hand, the anxieties and concerns of the less fluent speakers are not to be dismissed. After all, the ideal outcome would not be only to have more confident Spanish-speaking clinicians, but to have more competent providers. The concerns that less fluent providers raised about not being able to provide services in Spanish as well as they would like to, and the ethical and political questions that many of these clinicians ask about what it means that they may not always provide adequate care for their Spanish speaking clients, inform conclusions about roles for White clinicians in serving the mental health care needs of Spanish-speaking Latino/as.

Conceptualizing identity as White Spanish speakers

When asked what it means to them to be a White person who speaks Spanish, many participants described this identity as a complex one that has both positive and negative aspects. Participant Thirteen said that it's "one of those double-edged swords"; Participant Five described it as "both a positive and a negative thing"; Participant Twelve stated, "I have more short answers, because it's mixed, than one big answer"; and Participant Seven stated, "I think I'm kind of conflicted about it." The participants went

on to elaborate upon what they enjoy about speaking Spanish and what brings up concerns for them.

In their personal lives, many participants described their knowledge of Spanish as a source of pride, opportunity, and connection. Competency in Spanish has had a profound impact on not just the careers but the personal lives of many of the participants, including their choices of partners and friends, their choices in travel, and their leisure activities. According to Participant Thirteen, “It’s a wonderful window into another culture.” Participant Five described her Spanish language skills as a “source of pride of having learned another language.” Participant Six stated, “I love being able to have another language, and, by way of the language, access of connecting to people that I otherwise would not be connecting to... it's both a source of pride and a lot of personal satisfaction.”

Participants also mentioned professional benefit to their employment prospects, careers, and clinical work, to the agencies in which they work, and to Latino/a communities in general. Participant Seven said, simply, of her Spanish language skills, “I think it’s needed.” Participant One elaborated, “It means having access to clients that I otherwise wouldn't have access to, but more importantly, it means clients who are accessing services have someone who can speak their language, where otherwise they wouldn't.” Participant Twelve added that because the Spanish-speaking Latino/a population is growing quickly in California, and is already underserved, her skills feel especially critical. She stated,

In California... the population is growing really fast, also, and sort of balancing out that I’m able to help more people than some of my colleagues, you know, even if they wanted to, they couldn’t do it. So... I feel good about it.

Participant Seven also noted that her Spanish language skills are an advantage in terms of her options for employment. She commented,

Well, and jobs. It opens up so many options. I heard several of my White colleagues talking about how they were saying that the jobs that are available is close to doubled if not doubled once you speak Spanish. Like, it's amazing.

While most participants indicated that their Spanish language skills were a source of personal and professional satisfaction, more negative reflections, including feelings of regret, sadness, or frustration, emerged as many of the participants talked about the conflict they feel around being a Spanish speaker with limited Spanish language proficiency. Participant Five stated, "Sometimes it's a source of frustration, of, you know, doing something that I'm not one hundred percent competent at." Participant Six elaborated,

When I'm sitting with my clients, I often feel a little apologetic. And I express that. Because I kind of worry that they're not getting the best. They're not getting a completely fluent person who's also bicultural. Um, and, um, so a piece of me feels a little badly, that, by getting me, they're getting, sort of, substandard care.

Participant Twelve added that her feelings around providing services in Spanish are impacted by there being a lack of native Spanish speakers in her field. She stated,

There's a part of me that feels, um, I think sad is too strong of a word, but when I say that, I mean, I would like there to be enough people out there who can speak-who speak fluently, um, in their own family or culture so more native speakers or whatever, to provide this type of work already.

Participant Thirteen stated,

There is always the feeling that my language skills are not those of a native speaker, and I may be misunderstanding, or mis-explaining, you know, not being understood fully. And, so there is always a little bit of feeling that you're looking through a spectacle that may have, you know, some Vaseline on it, not totally clear, that is, distorted.

Some participants felt hesitant or conflicted about answering the question of how they thought about themselves as White Spanish speakers, not only because of both positive and negative aspects of this identity, but because they actually felt somewhat detached from their White identity. Several participants indicated that their Spanish language skills and interactions with Latino/a communities were extensive enough that, while they understood themselves to be White, they were not particularly aware of their White identity when they spoke in Spanish. Participant Ten reflected, “I don't really think of myself as a White person speaking Spanish when I'm providing Spanish language services, I guess. I feel more like a clinician providing services, and I'm aware that I'm doing it in Spanish.” Participant Four echoed this statement, saying, “I don't always feel like I'm a White person who's working in Spanish. I often feel like I'm a human being working with another in a common language.”

Several other participants responded that when they provide services in Spanish, they had a sense that Latino/a culture and identity had become, in a way, part of their own identity. Participant Two stated,

I mean, I feel bicultural. It's always been kind of a funny thing, because I look so *gringa*... It's meant everything to me, having that kind of perspective. And it's also been alienating, like from my family... my identity has been very shaped from all these experiences. And if I didn't work in that setting, I sometimes think that I, I mean- I don't know. I wouldn't. I'd have to somehow be that part because it's so much of who I am.

Participant Three echoed these feelings of connection with Latino culture, along with alienation from his own culture. He stated,

I've been so, so into Latin American culture that it's just all comfort for me.... It does not seem cross-cultural. I'm just there and that's where I'm supposed to be... I'd say I'm prejudiced because White is ugly. I remember when I came back the first time from Latin America after about five years, so I came back and I said,

"Everybody's sick! They don't have any blood! Everybody's dyeing their hair!
They're all blond!"

For Participants Two and Three, it seems that extensive contact with Latinos, both personally and professionally, gave them some distance from their own culture of origin that led them to think about it in a more critical way.

In understanding the diversity of responses in how the participants think about their identities as White Spanish speakers, it is useful to note how responses correlate with degree of Spanish language fluency. Participants with a range of language skills spoke of conflict in their identities as White Spanish speakers, and mentioned both positive and negative aspects of such. Even participants with high levels of fluency in Spanish and many significant personal relationships with Latino/as acknowledged differences in their language skills compared to those of a native speaker. This suggests that there is a central conflict to the identities of White Spanish speakers that persists whether the individual speaks proficiently or fluently. However, it was exclusively the participants with the highest levels of fluency and Latino/a cultural integration who felt that their identification with Latino/a culture was such that they were not as aware of their Whiteness, and may actually have felt alienated from White culture in some ways. This indicates that increased Spanish language proficiency, more time spent abroad, and more significant personal relationships with Latino/as seems to result in participants feeling more at ease with their Spanish language skills, including with the ways in which they continue to be limited, and less at ease with their White identities.

Participant motivations for providing Spanish language clinical services

The participants were asked to explain the process by which they went about choosing to offer services in Spanish, if they did have an identifiable process around making this choice. Participants actually described three different processes: the process of choosing to learn Spanish, the process of choosing to be a social worker or psychologist, and the process of choosing to provide Spanish language clinical services. These processes were sometimes intertwined, sometimes related, and sometimes more separate. Participants revealed a range of motivations for choosing to provide Spanish language clinical services that included personal, professional, and social justice related motivations, often in combination.

For many participants, their interest in Spanish language and Latino/a cultures, and their Spanish language learning, came well before they decided to pursue careers in social work or psychology. Participant Twelve recalled, of her decision to learn Spanish in spite of her father's encouraging her to learn French, "I knew there were more Spanish-speaking people in the country than French speaking, and I didn't see why I was going to learn a language that I wasn't going to possibly talk to someone on the street corner." Participant Thirteen applied similar meaning to an early decision to learn Spanish when he recalled,

So it was partly a conscious decision from when I was young that I wanted to learn a language that was relevant as a person living in the United States, um, but it was, um, you know, to work as a Spanish-speaking psychologist became, sort of, a logical consequence.

It seems that the decision to learn Spanish as a second language as a student, and to commit to continued learning of this language as an adult, may actually correlate with an

ethic of wanting to connect with Latino/a populations that may actually predict a later interest in Spanish language clinical work.

For several participants, their choice to pursue careers in social work or psychology actually followed their interest in Latin American culture and being of use to Latino/as. Participant Two recalled,

When I went to social work school I didn't really know what I was getting into. I wasn't like, "I want to be a therapist." It was like, "I want to do something that's related to Latin America, that's helping people."

She went on to specifically seek out employment where she could use her Spanish language skills and combine her interest in Latin America with her social work training.

Participant One also described her interest in Spanish language and in Latin America as pre-dating any particular career interests. She stated,

I didn't learn the language so that I would become a more employable social worker. I learned it because I love the language and I love to travel someplace where I can get to have an experience beyond a tourist experience, and feel like I can get more connected in a better understanding of where I am, by being able to communicate with, um, people all over the Spanish-speaking world. That, to me, is really a treasure. That's what motivated me to learn.

For Participant Five, her decision to use Spanish in her career also came as an extension of her interest in incorporating Spanish language and Latino/a cultures in her life. She added that committing herself to doing professional work in Spanish was also a way of making sure that Spanish language would stay a part of her life and a part of her skill set. She explained, "It was sort of a combination of loving Spanish, and wanting to use it in my work so that I don't forget it." Participant Ten described choosing her particular place of employment based on her interest in using Spanish. She recalled that, after becoming employed in a job where she was working almost exclusively with English speakers,

I decided I wanted to switch jobs, I wanted to work with a more diverse population that has broader clinical, you know, issues that come up, broader mental health issues, and I wanted to be able to use Spanish, partially because- part of it was to be able to use the Spanish and have that dynamic and work with Spanish speakers, because I feel very comfortable and close to them, and part of it was the realization that I'm never going to be able to speak Spanish again if I don't start speaking it every day, so there was some self-interest in that.

While some clinicians came into their careers or particular career choices through their interest in Spanish language and/or Latino/a cultures, others came into their interest in Spanish language and/or Latino/a cultures through their interest in social work or psychology careers. Growing up in an urban area with a large Latino/a population, Participant Four had always wanted to learn Spanish, but had not prioritized doing so. After he received his clinical degree, he chose to live abroad and learn Spanish as an issue of what he describes as “practicality.” Participant Eight decided to learn Spanish as she was seeking a particular employment opportunity. She stated,

It's more that I wanted to work in the agency I'm working with, and it's a requirement. I could have gone along learning Spanish outside, and never actually used it, but it's- I really like the agency that I work with.

While Participant Six had learned Spanish before she became a clinician, she stated that the issue of choosing to provide services in Spanish was also one of practicality and professional advancement. She stated, “It was because I really, at the time, wanted to transfer to *city name removed*, and wanted the job in *city name removed*, and that was the way to get it. It was a means to that end.”

Importantly, while the intention to learn and/or use Spanish in their clinical work started out as an issue of practicality for some participants, in all cases, their connection to the Spanish language and Latino/a cultures became more personal and intentional as they continued with their work. This was not, for any participant, a matter of rote

language acquisition because it was a pre-requisite or advantage in their career.

Participant Four, for example, stated that since being more immersed in Latino/a communities, he has come to see providing services in Spanish less as something he wants to do out of practicality, and more as something that he feels connected to doing and chooses to do. He explained,

The more I've been in [the Latino] community... I do feel connected to this community, and I'm always happy when, every now and then, some of the Latinos at my work call me an honorary Latino. So there's no questioning that there's a connection there.

Following her commitment to learn Spanish for more practical reasons, Participant Eight also described a turn towards a more personal focus of her commitment to providing services in Spanish. She stated, "I think that we all have to be really clear that it's pretty selfish... because I get a lot of satisfaction from it." She went on to explain that it is very satisfying to her to master a skill, relate to people with whom she wouldn't otherwise be able to relate, and learn about another culture. She described being able to connect with Latino/as through language as "a big gift".

For several participants, providing services in Spanish seemed more like an obvious result of the combination of their Spanish language proficiency and their clinical skills, rather than a choice. Participant One did not see herself as making a choice to provide services in Spanish. She stated, "It wasn't so much a conscious choice. I was there; I worked; I knew the language; I spoke it." Several participants mentioned that by indicating on their resumes that they had Spanish language skills, they were assumed to be offering these skills for clinical use. Participant Nine stated,

In all of the jobs I've had here, any place that I have worked or volunteered ever since I finished college, it's always been viewed as a plus on my resume, so I just

sort of take it for granted, which is fine with me, that that's one of the ways in which I'm gonna be able to be helpful or useful.

Participant Seven described her choice to provide services in Spanish as a logical way to use her skills to serve a population in need. She stated,

I feel like it just makes sense to me, because, if I have some language skills, even if it's not, you know, the primo, best of what I would like to have, you know, I feel like, I feel like I can be one small part of providing services, and there aren't enough.

In addition to the personal, professional, and social justice based motivations to provide services that are listed above, several participants spoke to there being a certain level of fortuitousness, or even mystery, to their decision to seriously pursue Spanish language learning and Spanish language work. Participant Five grew up with a family member who is native to Latin America speaking Spanish in the home. Trying to sort out how this might have impacted her feelings about including Spanish language in her professional life, she stated of her relative,

I'm closer to her now than I was to her then. Um, but I don't, she wasn't somebody that I was looking up to and wanted to be like. So I don't know if it just was something that I was around and heard and like, or, I'm not really sure.

Participant Three remembered,

In the beginning, I fantasized about going to Russia, and I studied the Russian language. But then, there was an opening going to Central America to do social work, really, with churches in this area, a jungle area of Central America. So I went. And then that was it- that has been my being since that time.

For this participant, it came by chance that he had an opportunity to live and do social work in Central America, but once he began the work, he felt extremely connected with it, like he had found his match not only for his career but for his life path.

Many participants described the choice to use their Spanish clinically not as a one-time event, but as a process that they continue to be in. Participant Thirteen knew that he wanted to provide services in Spanish from early on, but recalled more decision around when he was ready to provide these services. He stated,

I always had a sense that it was something that I'd like to do...I think that the, sort of, question for me was, at what point am I good enough in my Spanish skills to be able to start providing services?

He recalled that his qualms about providing services in Spanish were received by enthusiastic and supportive encouragement from his Latino/a Spanish-speaking peers, typified by the following: "Yeah! You might as well jump- we need you, and jump in, and you'll sort it out. If you don't understand something, ask." Participant Seven, who had just recently began to use her Spanish language skills clinically with regularity, talked about a similar initial anxiety around beginning to provide these services. She stated, in reflecting on starting work in a new location where she would be using Spanish more,

I was excited. I was both scared and excited about starting the new school, and speaking Spanish, and worried if my Spanish is gonna be good enough, and, you know... and, I'm really glad that I did, you know? And I just find it so advantageous in my work, because, I mean, I work with other clinicians who don't speak Spanish, and they have to, like, reject a case, because they can't relate to the parents, you know? And that stinks, you know? That's really not fair. So I don't- I'm glad to not have to be in that position. But I do worry that, you know, I'm providing services, but are they good- you know, are they good enough?

For this participant, as with many other participants, initial fear soon dissipated as she realized that she was able to be useful to her clients when the language of treatment is in Spanish. However, for her and for many other participants, a lower level anxiety persisted around whether her Spanish language skills, and her service provision, were

good enough that she should continue with the work. Participant Eleven described this ongoing struggle as follows: “I’m very self-conscious about my Spanish, so it’s always this, kind of, tug of war of, ‘Do I speak well enough to provide this service? Am I confident enough to provide the services in Spanish?’” While all of the participants did decide to continue to offer services in Spanish, in many cases, questions about this choice lingered.

Challenges to providing Spanish language clinical services

Participants were asked what primary challenges, if any, they encountered when they provided clinical services in Spanish. All participants described the work as challenging. Participant Seven recalled that, initially, doing therapy in Spanish was even harder than she had anticipated. She stated, “I was very, like, ‘I want to do this’, and then I did therapy in Spanish, and I was like, ‘Oh my G-d, I don’t know what I was thinking!’” She noted that the challenge and stress of the work actually manifested physically; she got headaches when she started to do intensive clinical work in Spanish. Of one particularly difficult home visit, she recalled,

That was the first time that I’ve gotten a language headache... And I don’t get headaches. But it’s like, because I was like, trying so hard to like, access that part- the language part of my brain... because my brain was literally growing in that language part, and you know, and so, it hurts (*laughing*).

Participant Five also spoke to the general difficulty of providing clinical services in Spanish. She stated, “I mean, social work is complicated by itself, and to add that I’m using a language that’s not my first language...” Participant Four spoke of feeling less comfortable providing services in Spanish as compared to English, a sentiment that was true for most participants. He stated, “It’s not the same level of comfort to express

yourself. And so sometimes that is challenging.” He also noted that Spanish language work requires extra energy and focus, stating,

I have to focus more, listening in Spanish... sometimes I'll kind of fade away in English, but, you know, it's more likely to enter anyway automatically in English, and in Spanish it doesn't necessarily do that. So I have to focus. Because otherwise, I'll just totally miss what they said.

Participants mentioned a range of areas where the challenge of providing services in Spanish was most evident. Several participants noted difficulties with their oral expression in Spanish, including vocabulary and grammar. Participant One noted a difficulty with some more everyday vocabulary that will come up randomly, but not too often repeatedly, in clinical work. She stated,

Because I don't really use [Spanish] too much outside of my work, there's certain vocabulary that's just not that active for me. Like, I really don't have too much occasion to talk about, um, using a broom to sweep the floor. So if I wanted to use that vocabulary in a clinical setting, I would be at a loss.

Participant Thirteen noted particular difficulty with physical health terminology, especially in the cases of patients with significant medical problems. Participant Three stated that oral expression is particularly difficult in Spanish because there are so many regional dialects and expressions. Some words and expressions he learned in Nicaragua may not make sense to a Mexican American. For example, he stated, “And spoiling, that's also a word that so many different countries have different names for spoiling their children. In Nicaragua, it's *mimar*. So I use *mimar*, and try to figure out, what word are you using for that?” Participant Seven spoke to the difficulty of learning slang. She said,

I had to have one of my clients my second year internship explain to me in Spanish what a gang was because I didn't know the word "*pandilla*". It hadn't come up, you know? So there's a lot of things that I just don't know, that aren't in the dictionary, you know, even if I, like, you know, flip my dictionary, it's not there.

Participant Four also noted that vocabulary was an initial challenge in his work, but one that could be addressed more easily than some other challenges. He explained, “If it's technical, it's harder in the beginning, but then you just learn the words... It's hard the first time and it gets easier. Vocabulary is just vocabulary.”

Certain grammatical constructs, phrases, or cultural ideas were difficult for some participants, and could get in the way of expression. For example, in thinking about how the conversation might go if she needed to say a grammatically complicated phrase like, “If you were to have”, Participant Six reflected,

I will think about, “Okay, how do I say this? Okay, wait a second, I don't- I can't remember how to say this quickly”, and then I don't want to take the time, we're running out of time... that's frustrating and time-consuming and, um, and yeah, sometimes the conversation suffers for it.

Participant Four explained that it took him some time to figure out how to communicate an exploratory phrase that he might commonly use in therapy, like, “What do you mean by that?” He explained,

And in the beginning, maybe, I wouldn't know how to say it right, and they'd act like I didn't understand the language, and I understand exactly the words that they speak, but I want them to be able to explore more.

Participant Five spoke to the difficulty of explaining broader concepts or cultural ideas in Spanish, especially ones that may not be familiar to her clients. For example, she noted that explaining what foster care is to a child who recently emigrated from a country where foster care doesn't exist is especially challenging in Spanish.

Other participants mentioned difficulties with their listening comprehension in Spanish, particularly with certain communication styles. Accent, use of slang or

modismos (expressions), and rapid rate of speech were particularly difficult to understand for some participants. Participant Ten recalled of a recent client interaction,

It was very unclear, because he was very anxious, and at that time, he was very difficult to understand. He stuttered, he had a horrible stutter, and he uses a ton of slang, and he doesn't finish any sentence that he starts. And he's very anxious. And so, it was just so hard for me to even- to provide any kind of an assessment.

Participant Seven noted that ambient noise tends to interfere with her listening comprehension in Spanish more than it does in English. She stated, "When there's any other noise, it's really hard for me to hear." Participant Nine noted that the "language of emotions" could be particularly difficult to understand. She explained, "In my formal training, and in my life abroad, or traveling, people would not necessarily be fighting, for example. And so when people are arguing or fighting, they use, maybe, more casual language." Participant One described a telephone interaction with a client who was difficult to understand as follows:

She called one day when she was, um, extremely anxious, and she was feeling not quite suicidal but very desperate, and she was crying. And in the conversation I couldn't understand probably a quarter of what she was saying. And I really wanted to, I really wanted to understand. But, amidst the tears and the crying- and that might have happened in English, too, where I might not have understood all of what someone was saying. But I felt that much more disadvantaged by it.

Participant Twelve also noted that it is harder to understand clients over the phone, because she cannot see gestures and facial expressions that may provide additional information. It seems that Spanish language involves an additional layer of challenge in situations where language comprehension may already be difficult.

Several participants noted that family therapy is a particularly difficult context for language comprehension, especially because there may be conflict within the family about what language should be spoken in the home. Participant Three explained,

The major problem these days, of course, is that everybody is trying to transition from being Latin American into being *gringo*, being, uh, part of American society. So that's why basically- kids will not even speak Spanish to their parents, who don't speak any English, and this is a major problem. So you go into the homes, you're dealing with these families, and the kids will only speak in English, and of course the parents only have Spanish.

Of this conflict, this participant stated, "I identify more with the adults who are Spanish-speaking, and I scold the kids for not keeping up with Spanish. I tell them that they've got to keep their roots." Participant Nine described a similar conflict around language in a family therapy context, and a similar understanding of her perspective on this conflict:

I think the hardest thing for me in terms of working with Spanish-speaking patients, is when I've had, you know, tried to do Spanish family therapy... when the children or the parents are mad, but having multiple people speaking in Spanish, and then, often, the teenager- often it was a teenager- responding in English, so I'm not only trying to understand and communicate, but I'm also trying to get the teenager to be respectful to their parents, and speak to them in Spanish, because that's their first language.

Participant Ten described a related family therapy experience in which she made a different therapeutic choice. She described, of an interaction with a young client,

I started talking to the kid in Spanish, and he was only responding to me in English. So I felt like now I've got this situation where, well, if I continue to speak to him in Spanish, I don't know how much of a conversation we're going to be able to have, because he's clearly saying that he wants to speak in English. But I'm not going to have an English conversation in front of his Spanish-speaking mother... So, um, I ended up asking the mother to leave, and we ended up having a really good conversation, me and the twelve year old.

In all these cases, the clinicians found themselves in challenging situations where they needed to use their clinical judgment to determine how language choice could serve the needs of the parents, the child, and the family.

Other participants noted additional situations where having proficiency in both English and Spanish added the challenge of needing to decide which language will be

most useful in a given situation. Participant Seven described her thought process when deciding which language to speak when reporting on a young client's progress during a school meeting as follows:

I had an interesting experience, actually, the other day, because I was at a meeting with the, um, service providers at the school, for the child, and, um, and the outreach coordinator was translating, and everyone was speaking in English, and then with the translation. And this was the mom that's bilingual, and the step-dad that speaks only Spanish. Um, and so, you know, it was my turn to kind of report on his progress, and I had this moment of like, well, should I do it in English? Should I do it in Spanish? Should I translate for myself? Like, I don't, I don't really know what I should do with this.

Participant Nine, who does neuropsychological testing, indicated that deciding in which language to test a child can be complex. She described that process as follows:

It's just hard to know even what language to test the child in. There are cognitive tests, you know, intellectual tests of intelligence that are in Spanish, and tests that are in English, but, um, it's often not necessarily clear if you should give a Spanish-speaking child a test in Spanish, because their formal vocabulary training may not be that rich in Spanish, and it may be, once they got to school. So, I actually have one test that's a bilingual verbal ability test, and that's where you give the child some test of verbal ability in English, and then, the questions that they miss, you administer them again in Spanish, and that's a nice way where you can sort of see how much better do they do in Spanish than in English.

Building a therapeutic alliance across cultural and linguistic difference was an area of challenge for some participants. Participant Ten mentioned that there seems to be a higher “no-show” rate for her Latino/a clients in comparison to clients of other ethnic groups. Participant Six also mentioned that some Latino/a clients prematurely end treatment, and wondered whether this may have something to do with language difference. She stated, “Some people drop out. Now, English speakers drop out of treatment too. Are Spanish speakers dropping out because of the language stuff? I don't know.” For Participant Twelve, building trust could be an area of challenge because her

Whiteness aligns her with systems of power that are looked on negatively by the family.

She stated,

I've had people tell me that that's a disadvantage for me, as far as people um, and actually that may have to do with [Child Protective Services]... because I have blond hair, and blue eyes, and that American look, that people may be mistrustful that I'm coming to take away children versus coming to help- that comes up a lot with child therapy.

She elaborated that trust with Latino men, in particular, may be difficult. While her primary therapeutic interaction is usually with the mother of her young clients, a father or an uncle is often in the room, especially in the beginning of treatment, watching how she interacts with the child and mother, but not engaged in the treatment. For this participant, this suggested some mistrust, perhaps both of the clinician and of the mother. Participant Eleven noted that Spanish speakers may be less familiar with psychological services, in general, and she may need to orient them to the services in a more extensive, deliberate way, than English speakers. A child psychologist working in a medical setting, she talked about needing explain to the parents of her patients what her role is and how she may be able to help, and to her young patients, "No, I'm not going to give you a shot; no, I'm not going to take your temperature."

Participant Twelve mentioned that there is a way in which the lack of familiarity with the language and with the culture may make her feel less safe during her home visits with Spanish-speaking families. She acknowledged that this may have to do, in part, with her own biases. She explained,

I have some safety concerns, and I think that's part of my own racism, you know? Like, um, some kind of assumption that I make just because of who someone is... I probably am more hyper-vigilant about how a man talks to his- his wife.

Several participants discussed differing views between the clinician and client on what constitutes child abuse as an area of challenge in terms of developing a therapeutic alliance with Spanish-speaking families. Participant Twelve reported that some of the parents with whom she works say,

“Well, in my country, you know, in Mexico, you know, you get a stick from the tree, and they get down on their knees, and you whip the child”- and it seems as though they know that you don’t- you can’t do that where they are, but, um, they’re also, you know, suspicious of what, um- I guess I’m saying.

It seems that both the participant and her clients expect that they will have different cultural orientations around physical discipline for children, but there is still discomfort from both sides around the clinician’s authority to enforce her orientation. Participant Three reported that differences are also evident in how he and his Spanish-speaking clients view sexual abuse. He stated,

Often, you see, because the kid was crying and they’d be cuddling the kid, and playing with the genitals to calm the kid down, in Central America. And then they come here, without any idea that these are going to be crimes, and of course, I had to think it was psychological harm that the kids underwent and had to consider them sexually abused.

Participants Twelve and Three both added that when they approach these issues of potential abuse mindful that these practices are culturally informed and are not conceived of as abusive by the clients, there seemed to be more room for working with the clients on changing their behaviors. Thus, the therapeutic alliance is challenged but not destroyed by these differences.

Several participants noted that the cumulative trauma experienced by many of their Spanish-speaking clients is a challenge in their work, and raised concerns for them around how much potential they might have to affect change. Participant Nine stated,

The lives of many of our families where the parent or the kid is Spanish-speaking are often really hard. There's so many different challenges and stresses on these families- you know, economic pressures, um, sometimes, you know, families that have been disrupted, of course by immigration, or separated from loved ones.

Participant Eight described the extent of the cumulative trauma experienced by many of the Latino/a clients that she sees as follows:

The big challenge for me, actually, is over time, coping with the extent of the pain that people bring to the table. Because there's a tremendous amount of abuse, and even though they're a healthy person, and they present with depression or anxiety, when you ask them questions, "Do you have any idea why, at this point in time, or where does that come from?" and they tell you that they were raped when they were five by a family member, ah, got pregnant at fourteen due to a rape and then their family threw them out because they thought they were promiscuous, and the level of domestic violence, et cetera, et cetera, that is happening in their home country, um, and that they've had to leave- women, especially, have had to leave their children on the other side of the border because their spouse left them and they have no way of earning money, and they come here leaving their children on the other side to earn money. There's a lot of psychic pain that you just have to deal with. So, that's the tough part. Getting rid of that at the end of the day.

She alludes to a need for additional coping mechanisms to manage the enormity of the trauma that she must hold.

Problems with structural support from participants' agencies of employment in the service of Spanish speakers also contributed to the challenge of serving Spanish-speaking clients. Participant Twelve stated that some important intake paperwork is not available in Spanish within her agency, so she needs to either take a lot of time to orally translate the forms, or ask her clients to sign something that they do not understand.

Participant Nine reported frustration that she does not have time to translate the patient reports that she prepares into Spanish, and her agency of employment has not been open to the idea of funding the translation. She reported,

I've asked at different times, you know, whether we can get something translated, written reports, and it seems unclear how that could possibly happen here. I think I've come across a brick wall when I've tried to have that done.

Participant Six noted that, because her agency does not offer the same group therapy opportunities to Spanish speakers, she is left with more responsibility for her Spanish-speaking clients' care. She described her difficult decision-making process around how best to serve a client in need of immediate services as follows:

I have to think about what's going to work for this person in the three weeks that I really don't have time to see them, um, to manage their situation adequately, or, maybe I should just try to squeeze them into my schedule somewhere, which always has an element of backfiring, because then I'm strained...

Shortcomings in agencies' commitment to providing services to Spanish-speaking clients, and thus, their support for existing Spanish language services, have major consequences for client care, and are also felt acutely by the providing clinicians.

Some participants felt challenged by the limits to how they could understand and empathize with their Latino/a clients, given linguistic and cultural barriers. Participant Thirteen reflected that he is not sure "how much I can understand where somebody else is coming from who comes out of a very different culture from mine." However, he considered,

I think, um, I feel perhaps more comfortable in that realm because I've spent a fair amount of time traveling in Latin America, and have significant relationships with family members, yeah, family members and friends, and I feel like pretty much every psychotherapy relationship, every human relationship is cross-cultural on some level, so I in fact feel more comfortable with that.

Participant Two noted a similar sense of growing more comfortable with her capacity for cross-cultural understanding over time. However, of her early days in the field, she reflected,

At the beginning, when I was younger, and more just inexperienced in the field, and just didn't feel very authoritative about anything, and I just felt very like defensive and like I wasn't a parent, I wasn't very old, and I was a *gringa* (*laughing*) and like, what am I doing here?

For clinicians Two and Thirteen, their confidence that they could be useful to their clients increased as they continued with the work. For other clinicians, however, concerns around their effectiveness and frustrations with challenges of the work were not as easily resolved. Participant Twelve indicated that the extent of the challenges of cross-linguistic work, social and educational injustice, and difficulties with support from her agency of employment, led to some significant concerns around her potential to be useful to her clients. She explained,

So there's a level of, sort of, hopelessness (*laughing*), in some of the poorer schools, not just for Spanish-speaking kids, um, so, you know, if you have a Spanish-speaking family who's really struggling, um, you know, to, to provide here in a difficult, challenging, maybe violent neighborhood, where they don't feel safe, and in a lousy school, there's so many obstacles to, um, to helping things change or improve, I don't think enough of what I do to think that I'm going to be able to make a huge difference in those situations, even though I would like to.

Participant Seven struggled with a reaction she had of blaming her Spanish-speaking clients for not being as useful to her in navigating the challenges of the cross-cultural, cross-linguistic work as she might have liked. She explained,

When I speak to someone who, and I'm speaking in English, and I know it's their second language, I try really hard to really announce, to, like, make eye contact, to speak- not really loudly, or really, you know, like, really slowly, but, you know, like, I just pay attention to really slowing down my cadence, and just making sure that they're following me. And I felt frustrated that [a client] wasn't doing that for me. And I was like, "G-d, I want her to take care of me", you know? And that's not fair, because she's receiving services from me; I should be able to deal. But, when there were screaming children, and, um, she was, like, not looking at me, and, and talking really fast, and I was like, I got this massive headache from, like, half an hour in the home. And I was just, like, having a really hard time.

The question of how to maintain hope and a positive regard for clients, given significant barriers to change, is evident in these two challenging instances.

Many participants do find creative ways to manage and navigate the challenges of cross-cultural, cross-cultural work. Many participants made a habit of bringing up differences in language and/or culture in their initial encounters with their clients, and encouraged communication around these differences. These statements took different forms for different participants. Participant Eleven tells her clients, “If you don't understand me, any questions, please, I'll try to understand you, but please, let me know, I can always get somebody to help out.” Participant Thirteen says, “I'm not a Spanish- I'm not a native speaker, and if you think I've misunderstood something, please tell me. Um, if you don't understand something I've said completely, please ask me.” Participant Nine says, “I usually start speaking in Spanish, and I say, 'I'm sorry, my Spanish is not terrific.’” Participant Six said,

I apologize for not being fluent, and say, you know, “It's gonna be obvious to you, and if, by chance, you prefer to see someone who speaks fluently, who speaks fluently, I will arrange that for you. Um, we do have people here in the department who are bilingual and bicultural, and if for whatever reason you prefer to see one of them, I will facilitate that transfer.’”

Participant Four asks, “How do you feel about the fact that I'm not a native Spanish speaker, and I'm not Latino myself?” While participants reported that these statements generally did not open up much conversation in the moment, they may open room for the discussion of difference or language concerns later in the therapy.

Participant Eleven noted that using self-disclosure around the feelings she has when she provides services in Spanish is helpful in joining with the client to address some of the challenges of the interaction. She reported,

If I find myself, and sometimes this happens, where I'll be talking, and I'll look- I can see their face, and they're struggling (*laughing*), and I think, "Ok", I'll stop and I'll say, you know, "I'm sorry, but I'm really nervous right now, trying to explain this." And they'll say, "No, no, no." And you know, I'm not looking for reassurance, but I want them to know what's going on for me.

Several participants reported that general empathy, relationship-building skills, and use of difference that they have developed as clinicians are useful in managing the challenges particular to cross-linguistic work. Participant Thirteen stated, "At the end of the day, I really think that social workers build relationships, and if I can find a way to do that, in spite of the language, then I don't think it matters so much." He described asking for help with certain words, when necessary, as one way to build rapport with his clients. Participant Eight mentioned, similarly, that her general skill in building relationships serves her well in cross-cultural, cross-linguistic work. She said, "I think I'm pretty good at joining with someone, regardless of where they come from."

Several participants mentioned using humor as a method of joining with their Spanish-speaking clients around difficulties in understanding. Participant One noted,

I regularly and truly admit when I am missing some words in my own vocabulary (*laughing*). And we can laugh about that. Sometimes, [a client] can teach me a new word, and we do an exchange. And I think [my client]- she likes that.

Participant Twelve noted that, initially, if she can tell a client does not understand what she is saying, she will try to explain it in a different way. Then, she and the client use humor to diffuse the tension around this point of misunderstanding. She stated,

I'll kind of laugh about that, if I tried and it didn't work and then I got it, and the person I'm speaking with initially laughed too, and it's kind of a release, because it's a moment of... that I kind of jumbled up.

Many participants reported that becoming more comfortable and direct with telling their clients that they do not understand has been extremely important in their

navigation of linguistic difficulties. Participant Three said, “I don't have any problems to say, ‘repeat, repeat’, whenever it's necessary.” Participant Nine noted that, in moments of difficulty in comprehension, she considers, “Do I want to interrupt them and have them explain it more? Is it okay that I got the gist? Did I get the most important things?”

Participant Thirteen uses his clinical judgment in the process of deciding when to ask for clarification. He stated,

And I do frequently, you know, I have to make a judgment about how often I interrupt and ask, and how much I assume that I've gotten enough of what somebody has said to not break the flow, and be helpful.

Participant Twelve reported that it is actually better for the therapy and for the relationship to clarify misunderstandings just as they start. She pointed to the benefit of,

Just erasing any shame issues that I have around that I should have heard it, because one of the most, you know, a couple of times I've done things where I'm like, “I kind of got it, so they can just keep talking and we'll get through it”, and then I realize I'm lost, and then, having someone say five sentences and then saying, “I didn't get that”, is very different from someone starting a sentence or getting halfway through and then saying, ‘I'm sorry, could you just start that again?’ And, I've found that that's just really serves me, because, um, it seems to me that instead of someone who's speaking Spanish being offended by the fact that I didn't understand them, again, it feels like I'm taking it seriously because I want to get it right.

In making sense of the array of challenges mentioned by different participants, it is again useful to consider how responses distribute in terms of participants' language fluency. Less fluent participants struggled more with issues directly related to the Spanish language, including vocabulary, grammar, and phrasing. While those with more fluency continued to struggle occasionally with certain linguistic challenges, these points of difficulty did not seem to disrupt the work as much as they did with their less fluent peers. Those with more Spanish language fluency tended to struggle more with the

culturally-based challenges to the work. While participants with less fluency did sometimes mention cultural aspects of the challenge, there was a need to focus so much on language expression and comprehension that there was sometimes not room to focus on some of the more complex cultural pieces. Across the board, a lack of support from agencies of employment amplified any challenges that participants experienced with their clients, and added new challenges into the mix.

Client responses to participants

Participants were asked how their Spanish dominant Latino/a clients respond to them as Spanish-speaking providers. Many participants noted that in general, it seems that their Spanish-speaking clients respond very positively to them. Participant Eight noted, "They are very accepting." Participant Nine finds that when she apologizes for difficulties with her Spanish, her clients often reply, "Oh no, you speak very well." Participant Eleven noted similar feedback, when she stated, "Most of the time, they'll say, 'Oh, you speak well. I understand you. I understand you.'" Participant Four commented,

I think ultimately there's an acceptance because of it, because we're bringing it up and making it an issue. I remember asking one guy once, how he feels that I'm not Latino, I'm working with you, I'm not a native Spanish speaker, and he said, "Well, I appreciate it, because you actually took the time to learn our language, so I'm glad that you're working with us."

Participant Four also noted that clients often tell him about previous positive experiences that their children have had with White professionals, such as teachers. He reflected, "You could interpret it, well, they're trying to reassure me, but I think they're trying to reassure themselves more than anything else." Participant Eleven stated, "My experience

has been one of a lot of appreciation, and respect, and warmth, and, ah, oftentimes much more so than my non Spanish-speaking clientele.”

Positive responses from clients came not only in the form of overt feedback, but also in clients’ ability to make use of the therapeutic relationship, and how much of themselves they chose to share. Participant Ten stated, of her Spanish-speaking clients, “They open up to me, they tell me things that they haven’t told the doctor, or are embarrassed to tell the doctor, um, they allow themselves to be emotional, and tearful...”

Participant One talked of a transference that has developed between her and a Spanish-speaking client as a sign of a strong therapeutic alliance. She stated,

Within the context of her own community and her own family [the client] does not talk about her feelings to anyone, ever, and she’s so grateful to have the chance to do that with me, and I think she, um, she only has sons, and I think she feels like I’m a daughter to her in a certain way, so there’s a lot of warmth there.

Participant Thirteen described his Spanish-speaking clients as being particularly eager to engage in the work. He stated,

I get a lot of people who are just like, they come in and they’re ready to work. Um, and it’s just wonderful to see, because I often just don’t see that kind of readiness and enthusiasm in the English-speaking community.

He wondered whether a recent increase in psychological commentary in Spanish language media might contribute to this enthusiasm.

Some participants wondered whether the positive feedback they were given by their Spanish-speaking clients was deserved, or was influenced, at least in part, by clients’ desires to be accommodating. Of her Spanish-speaking clients’ responses to her, Participant Nine stated, “If anyone has had negative reactions, they’re too polite to share them with me.” She wonders whether her clients’ English may sometimes be better than

her Spanish, but again, they are too polite to initiate a language switch to English. Of her clients' gracious feedback, Participant Six stated, "Maybe they're being polite, they're so grateful that someone- anyone speaks some Spanish... so maybe they're just so grateful, and they're used to getting less than, it's not a big deal- but who knows?" Participant Eight wondered if her clients may respond positively to her as a provider because they are aware that they do not have a choice to see a native Spanish speaker. She noted, "They are very good about it. It's not really a choice between me and someone who is bilingual and bicultural. It's me or nothing. So, and I think they're pretty aware of that." Several participants indicated that their Spanish-speaking clients rarely to never requested a transfer to another clinician, even when a transfer to a native Spanish-speaking clinician was offered.

Participant Eight noted that many of her Spanish-speaking clients may respond positively to treatment because many are coming to therapy for the first time, the process of disclosing information, including trauma, alone, and being validated, can be extremely powerful. She noted,

A lot of these women, in speaking with me, it's been the first time that they've revealed rapes, or incest, and they carry it with huge shame. And, if whoever's receiving it can try to normalize it, and not repeat their feelings of shame, it- it can be very helpful, I think.

Participant Ten confirmed the value that her Spanish-speaking clients receive simply from sitting with someone empathic for the first time and being heard. She stated, "Sometimes when I sit with these people, and like, they haven't talked to anyone. And there's just so much isolation, and I think so much gratitude just to feel like they're gonna have some support."

For some participants, it seemed that they were more critical of difficulties with their language skills than were their clients. Participant One noted, “I always think that I’m less clear than they tell me that I am. I think I might be more critical of my language competency than some of my clients are.” Participant Eleven wondered about the following compliment she received from a co-worker: “Your Spanish is really good; I never notice any mistakes.” She explained, “But I don’t think Spanish speakers really- I don’t always trust that (*laughing*), I don’t know. Because I know that I make mistakes, and I hear them.” She goes on to explain that some mistakes, like poor accent or incorrect gender for nouns, seem to be particularly grating to native Spanish speakers’ ears, while they may barely hear other kinds of mistakes. Participant Thirteen also noted some difficulty with determining how much of his clients’ positive feedback was genuinely related to his skills, and how much it was more out of respect. He stated, of his clients’ praise, “It might not be over-generous. They might really mean that very sincerely (*laughing*). On the other hand, they might not feel comfortable saying, ‘I’m really having a hard time understanding you. Could you repeat that?’”

Only one participant, Participant Three, described an overt negative response from a Spanish-speaking client around an issue of language or culture. He described an occasion where a group of White providers were meeting with a Latina Spanish-speaking mother during an intervention. He recalled, “But she says, ‘You’re rich and you’re authority figures. You don’t understand us. We’re just dumb people.’ And so, that’s part of the problem, that there is a division there.” This interaction is different from ones described by other clinicians in that there was a team of White providers, including Child Protective Services staff, meeting with the client, rather than a single clinician. Thus, it

may be the case that a client may feel overwhelmed by a team of White providers, or by providers with certain agendas, and be more prone to develop a negative reaction and/or transference. While Participant Seven did not have an overt negative response from a client, she wonders how her language skills and Whiteness may impact how committed the parents of her primary clients may be to using her recommendations. She stated,

The parents I work with in Spanish seem very appreciative, and very open, but for the most part, um, but I, I'm not sure how much of a difference I'm making. Um, and I do feel like the fact that I'm not super-fluent and I'm not Latina definitely hurts in terms of me being taken seriously.

While few participants recalled specifically negative feedback from Spanish-speaking clients around issues of language or culture, many participants noted some surprise, curiosity, and sometimes awkwardness, from clients as they tried to understand how it was that the apparently White service provider in front of them was speaking Spanish. Participant Eleven noted that when she picks her patients up from the waiting room for their initial appointments, “My patients sometimes will look, because they can see, and they hear, and it's that initial sort of- are you speaking Spanish? Ok, you are, ok. And then, ok, let's go.” Participant One noted that her clients often “took an interest in me, in where I was from, or how did I learn to speak the language, and interesting assumptions that were made sometimes about my own racial or cultural identification.” They sometimes assumed that she was native-speaking, which this participant reports “surprised me because I don't think that my language skills are that good.” Participant Thirteen spoke to a similar experience:

I'll almost feel like they're pulling my leg when somebody will ask me, ‘Well, what country are you from?’ People will assume- if they're from Mexico, they might assume that I'm from you know, Venezuela, or Honduras, or, you know, Argentina, might be a guess.

Participant Seven described similar interactions as follows: “I do feel like there's this initial, like, wait- you don't look Latina, and you're speaking to me in Spanish, and you definitely have a *gringa* accent.” She went on to say,

I do feel like there's more of a hurdle to get over, um, the initial- I feel like it takes... I fantasize that there's more of a hurdle to get over in terms of establishing rapport, and figuring out who each other is, before really getting into a lot of the work.

Participant Four reflected, “I have an accent, and so sometimes they wonder in the beginning, can this person actually communicate with me. And then, after a while, they realize that I can.” The participants generally describe the phenomenon of clients wondering about their identity or language skills as an initial area of anxiety that is soon overcome.

Navigating cultural difference between client and therapist was sometimes perceived of as a challenge. Participant Five stated,

There are some [clients] who might feel like, culturally, I'm not going to understand, so it's easier for them to open up to somebody who is from- and sometimes it's specific to what country they're from, not just being Latino, but they want to speak to a Guatemalan, um, who's going to really understand their experience.

It seems that some clients come to therapy with culturally based ideas about who can best be of use to them, and these are then reflected onto the assigned clinician.

Several participants mentioned that their Latino/a Spanish-speaking clients, as compared to clients from other racial groups, often expect or want them to assume a more directive, or even authoritarian, style. Participant Two noted, “It can be in certain instances, people just come and are very, I guess, expect a *consejo*- just tell me what to do.” Participant Five remarked, “I've even once in a while been called Doctor, which I'm

not (*laughing*)”, which to her indicated a high assigned level of authority, even higher than would be accurate. Participant Thirteen noted a similar deference, and talked about both his discomfort with this stance, and how it might be used in the therapy. He stated,

There’s a lot more, kind of, deference to authority among my less educated, lower income Hispanic or Spanish-speaking clients, and, um, I find that’s always an area where I feel like I’m feeling my way through those glasses that are smudged, and, on the one hand, I think it can be helpful to use the authority that is afforded to a doctor or a professional in a very respectful kind of way, that- that you might not get with Caucasian or other American-born folks. So it can be helpful in terms of saying, “This is your homework. Please do this.” Um, I find that a lot of my Spanish-speaking clients really listen to me more carefully, and do the things that I’ve suggested that they do. On the other hand, I think that there can be a tendency to not speak up if they’re not understanding something, or if they’re feeling uncomfortable, or like we’re going in the wrong direction, um, so, it’s hard because that’s a little trickier to negotiate.

Participant Twelve said,

I think sometimes being Caucasian can be similar to being, you know, like a doctor figure or an educational figure, because- and again, it goes both ways- but there is an assumption, sometimes, when I come in, that they sit down and they listen and they want to know what I have to say... there’s an idea that if I am a professional somehow who’s come- you know, someone who I’m from this new country, and I can just- I can help.

She added that some Spanish-speaking clients refer to her with professional titles that are more culturally familiar than “therapist” or “psychologist”. She described,

The word “teacher” comes up a lot in Latino families, because they don’t call me a therapist. Um, they call me a teacher. And I think that, to me, is a combination of, one, they feel more comfortable because psychotherapy, in general, and psychiatry, is looked at as very um, you know, negative, like, you’re really, really crazy if you have to see a therapist in another country, or, um, whereas you sort of avoid that.

Several participants noted that race and language skills were only two factors out of many that determine how their clients respond to them. Participant Eight explained,

Acceptance in social work, therapy- it’s on a matrix. I mean, so, how do you dress? How do you look? What’s your tone? How old are you? Are you gay or

are you straight? I mean, it's got to- all those things influence you. And, the patients come in with all those too.

Participant Four notes that gender difference often feels more salient for him than linguistic difference at this point in his work. He noted, “[Language] is not my primary focus anymore. It's become more, I work more with females than men, so sometimes that, when I'm thinking about differences, jumps out more.”

Participants were also asked about observed or imagined differences between how their Spanish-speaking clients respond to them and how clients respond to Latino/a colleagues. Several participants mentioned that this question was difficult to answer, in part because some had not had opportunities to witness their Latino/a colleagues in their clinical work. However, others had had more opportunity to shadow Latino/a colleagues, and felt more able to respond.

Participant Eleven noted that the initial meeting of a Latino/a clinician with a Spanish-speaking client seems to be smoother. There is not the confusion with a White provider around whether or not and how well the provider is able to speak Spanish. Participant Thirteen described this ease as such: “There's a little more cultural connection, a little more, ah, grace, with knowing how to really welcome people in a way that must feel totally like, you know, two people from the same culture greeting each other.”

Several participants mentioned that their Latino/a colleagues often have a higher level of Spanish language fluency, which allows clients to express themselves with more casual language or with greater speed. Of a Latina colleague, Participant Eight reflected, “I mean, she's definitely much better at picking up on colloquialisms, and things like

that. She's got to be better at it." Participant Twelve noticed that Spanish-speaking clients speak faster with native speaking clinicians. She stated,

When the parents are talking to someone who's, you know, fluent, which I'm not, it's obvious that they- they change the pace of the type of their speech, which makes sense. So they can speak faster to someone who's fluent speaking, and they can kind of cut words and that's okay.

She wondered if it might be that the conversation and therapy is more intense between a native Spanish speaking clinician and a Spanish-speaking client.

In terms of other stylistic differences from Latino/a colleagues, Participant Eleven noted that a Latina colleague of hers tends to be both more playful and more directive with her clients. She observed,

Like, for example, we're talking to an older woman with possible dementia... and [the colleague] just talking like, "Oh, yeah, you must have been a little diva when you were younger", and you know, the woman's laughing, this cute, you know, older woman. And I'm just thinking, you know, I would have never gone that route with someone. I've just felt the need to be much more respectful. And I've noticed it too with the parenting, um, she's very hard on, like, boundaries, in terms of like, "You need to do this. You can't let your kids walk all over you."... And it's, yeah, like, I don't- I tend to do more an information gathering, and, "How is that working for you?" kind of technique, and soft suggestions, and I guess that it could partially be style, but I watch the response of clients when she treats them in that familiar way, and they seem very at ease and receptive. And so, I think that's a piece that I don't know if I'd ever- ever have.

Participant Seven noted that her Spanish-speaking clients seem to be more open and forthcoming with a Latino colleague of hers. She explained,

The Family Resource Coordinator is at my school, and he provides me all of my referrals, um, and he's a native Spanish speaker. And, um, and I feel like he- parents are much more open with him a lot of times. You know, he'll say to me, I really want you to see this kid, because such and such and such happened, and, you know, I'll say to the parent that *name removed* told me that, you know, things happened, can you tell me a little more about this?... So then they'll tell me, like a snippet of it. Um, so sometimes I feel like I don't get the whole story.

Several participants cautioned, when comparing how they and Latino/a colleagues interact with Spanish-speaking clients, that Latino/a identity does not correlate directly with fluency in Spanish or knowledge about Latino/a cultures. Participant Eight noted,

The only thing is that the truth of the matter is that people these days that claim to be bilingual, bicultural often are neither. Because being born here doesn't make you bicultural, even if you're born into a Latino family... So, but we have had a problem with people who appear Latina, Latino, in fact not being bilingual, or not speaking as well as you might expect that they would. And not truly being bicultural.

Participant Five spoke of some discomfort around learning that her supervisor, a Peruvian American who grew up in the United States, had less fluency in Spanish than she does.

In sum, Latino/a clients tended to respond remarkably positively to the participants. In all of the clinicians' combined experiences, in providing Spanish language clinical services with varying levels of Spanish language fluency, only one overt instance of a client responding negatively to the clinician around an issue of language or culture. Clients tended to be appreciative of the participants and forgiving around any difficulties in their Spanish language skill. Still, participants noted that clients seemed more at ease with a Latino/a clinician, especially initially, and noted that Latino/a clinicians seemed to be able to be more casual with their clients and to make interventions in a more familiar, culturally congruent way.

Referrals in Spanish language clinical work

Participants were asked to explore treatment decisions they make in the care of their Spanish-speaking clients with a question as to whether they had ever referred a Spanish-speaking client to a provider who spoke Spanish natively, or wished that they could. All participants but one noted circumstances in which they wished they could

refer a client to a native speaker, although very few were able to or chose to make frequent referrals. A number of participants noted that this option was not available to them, given the set-up of their agency and the backgrounds of their colleagues.

Participant Ten stated that there have been times where she has wished she could refer, but, she said, “I haven't, just because the expectation is that we take care of it, you know, first of all. Second of all, there's not really the time or space to do that effectively.” In cases in which participants were not able to initiate a transfer, they were asked for the purposes of this study to consider cases that they wish they might be able to transfer to a native speaker, were this to be an option.

Some participants were in clinical situations where they routinely referred to providers outside of their agency for services like more extensive therapy or psychological assessment. Several mentioned that, while they felt they were able to complete their clinical role adequately, they were glad to be able to refer out to native Spanish speakers for other kinds of work. Participant Five, whose jobs consists mainly of clinical case management, noted,

One of the things I struggle with at this job is not being able to provide therapy, and kind of wanting to be in that role with some clients. But I do feel like with the Spanish-speaking clients it's sometimes like a sigh of relief. Like, I'm here and I'm helping you and I'm in this helping role, but there's also going to be this person who is a native speaker who might pick up on anything that I've missed, or, you know, might be culturally a better match.

She noted that this sense of relief was particularly true in the cases of clients who have experienced significant trauma. She described one such case:

I have a client now who, um, was raped several times in Guatemala, and she's kind of on her own here. She's sixteen, and she's pregnant, not by her rapist, luckily. But she's just got a lot of things going on, and as much as I think- I've been very involved with her, more so than with a lot of clients, but it's still, kind

of, a sigh of relief for me that she has that really regular, um, therapy time, and that it is with a native speaker.

Participant Seven noted,

I have gotten psychological evaluations done by bilingual clinicians, partly because I felt like- well, there were very good reasons to do a psychological evaluation, and I felt like I needed that extra assistance, but I also felt like, maybe they'll catch something, you know, that I've missed with the language barrier.

She also mentioned particularly valuing the services of a native Spanish-speaking provider in a case where a client's presentation suggested a traumatic history, but her client had not disclosed any trauma. She described her internal questioning process as follows: "Am I just missing something? Am I just not reading the cues? Like, what's happening?" She stated that she appreciated having access to a second opinion from a clinician with more command over the Spanish language.

Several providers indicated that most or all of their clients would benefit from seeing a native Spanish speaker, were the option available. Participant Nine noted, "All of [my clients] would probably be better off with somebody who could speak it fluently." Other participants indicated that they felt similarly, that a native Spanish speaker would be their first choice for most or all of their Spanish-speaking clients, but their supervisors or referral sources did not share this opinion. They reported that their referral sources generally assumed that all identified Spanish language providers possessed similar skills, and made no differentiations between native and non-native speakers. Participant Seven explained, of a clarifying conversation with her referral source,

One thing I said was, you know, if there's a child who- children who are highly verbal in Spanish, you know, it may be a good idea to refer them first to the Latina clinician there, um, she's there one day a week, so it's like, you know, my Spanish is workable, but it's, you know, I'm not bilingual.

Participant Ten said, of conversations with her supervisor around her case assignments,

He's not differentiating. This is an ADHD case, so I'm gonna take it, even though it's in Spanish... I always look at the language and the culture first, and my boss does not... I think it probably has something to do with my confidence level, versus what he thinks about me, and then what he imagines my skills level versus what I perceive it to be. So there is some discrepancy sometimes. But in that moment, I can look at him and say, "You know, *name removed*, I'm looking at this, it looks a little too complicated, I don't feel comfortable.

Participant Nine mentioned that, in her larger professional community, many of her colleagues would encourage her to refer Spanish language cases out to a provider who is more fluent. She stated,

If I talk to my colleagues in the [neuropsychology] community, they would say, 'Refer out to someone in the community to do this, so they could do it better', or, you know, 'It's not the thing to do', and that kind of thing.

However, within her agency of employment, she was encouraged to continue to do the work.

Participant One noted that she is much more selective in accepting Spanish-speaking clients in her private practice setting than she is in her agency setting. She explained,

There was a family- a monolingual Spanish-speaking family- that wanted [private] family therapy and I declined, just because I- I didn't feel, um, competent enough to do it, actually. I really wanted them to have someone who was- either a native speaker, or more bilingual and certainly bicultural. I think they needed that, given their presentation. I'm pretty selective in my private practice setting, about when and how I use language, um, and in my agency setting I'm less selective. Mostly because there's an alternative in the private practice.

For this participant, referral to a bilingual, bicultural clinician is preferable for many clients, but is more of a possibility in a private than in an agency setting.

Some participants pointed to specific client profiles in which the client might benefit from a native Spanish-speaking clinician. Participant Eight noted that for men, more than for women, she would consider making a referral to a Latino/a provider, or in this case, specifically, a Latino male provider. She stated,

Because the whole machista thing... I think that men who buy into that do not- do not, yeah- they would have to, I honestly believe they would have to relate to a bicultural. You would have to be bicultural under these circumstances, and male. Someone who was a bicultural person, who would be able to tell them, 'Yes, there are choices. Yes, there is a different way of doing it.' Because... otherwise I just don't think you could do it.

Participant Thirteen noted that patients with thick dialects were challenging enough early in his career that he might have wished that he could transfer certain cases. He noted that this is no longer as much of a problem, although he did mention, (*laughing*), "I wouldn't want to do therapy with my father-in-law, because he uses way too many *modismos*, way too many idiomatic expressions." Participant Twelve also indicated that significant language comprehension issues may also necessitate a transfer. She mentioned one particularly rapid speaker as a good candidate to consider for a transfer.

Several participants indicated that cultural differences between the clinician and certain patients could spur difficulties with the therapeutic alliance that might lead them to consider a transfer. Participant Thirteen recalled a few cases of clients where there seemed to be an issue with the therapeutic alliance that may have had something to do with culture, and may also have had other factors. He would often refer these clients to group therapy with a Latino/a provider, and ask for consultation, or occasionally, transfer the case. He stated,

I think that a couple of the people like that, where it felt like something was a little bit off, where I just was understanding what they were saying, but I just

didn't quite understand what they were about... it felt more like those were just sort of therapeutic mismatches than language mismatches. You know, maybe, perhaps, some of the therapeutic mismatch was a cultural thing too.

Participant Two noted that in a previous employment setting, some clients would prefer to see a Latina colleague of hers who was a psychologist and a *curandera*. She stated,

There are people who won't go to a White clinician, you know? They'll go to a cultural practitioner in the community. And they'll go for a *cura*, they'll go for a *curandera*, they'll go for a *santero*, they'll go for a *salvador*, you know, they'll seek out a different approach, even though what they're probably really seeking is some kind of a mental health service. But they won't- they just won't even go in that direction.

Participant Twelve stated that for clients who come from rural regions of Latin America, issues of cultural unfamiliarity can complicate the therapy and might lead her to consider a transfer. She stated,

My lowest really fear in this path is, I feel like I can't give back enough, or even take in enough, because of, um- sometimes I think of things like customs, or even lore, like stories, that I don't understand, that are referred to over and over, and then they have to explain it to me.

She noted that while it might occur to her that a Latino/a provider might do better with a particular case, consultation with a Latino/a provider can often provide enough information and guidance that she feels comfortable continuing to provide treatment.

Also in the realm of cultural difference was a comment from Participant One, who indicated that a Latino/a provider may be more useful in bridging a cultural gap between a parent and child in a family treatment situation. She reflected,

With a number of kids that were U.S.-born to immigrant parents, the parents didn't really speak English, and the kids didn't really speak Spanish. Neither one really spoke effectively with each other, because the kids were so acculturated and the parents were, for a variety of reasons, really absent... So, in those cases, the number of times that I actually would facilitate communication between them, and really wanting them to have a- not just a native- I think preferably a native speaker, because I think for the immigrant parents something about that would

really help- but someone truly bilingual, and bicultural, I thought would really help bridge the kids and families, in relationship to the other.

For other participants, a native Spanish-speaking clinician might better carry out specific types of clinical work. Several providers mentioned that, for long-term therapy, they would refer to a Latino/a, native Spanish speaker, were the option available.

Participant Eight stated,

For long-term therapy, I think it would be better for a person to work with someone who is the most fluent. Just because with long-term therapy, my assumption about long-term therapy is that there is a lot of stuff that needs to be dealt with. So the more severe, the more traumatized, the longer the therapy, the more important that there can be someone who can connect with every word.

Participant Two wondered,

I've thought about, would I want to do analysis? Because I was in analysis myself, and I think that be hard. Because there's so many subtleties and there's so much only- I mean, there is about the space, and the rhythm, and the, kind of, what are the repetitions, and the mannerisms, and there are- you know, there are a lot of analysts who are from other countries, and they do analysis in English. But I would feel like I would need to take my, I would need to study more academic language, just- I don't know, I would need to really immerse myself in a literary Spanish world.

Participant Eleven noted that for the more in-depth work required by sexual abuse or incest, she refers to a Latino/a, native Spanish-speaking provider.

Particularly complex clinical or diagnostic issues led some participants to consider a provider transfer to a native Spanish speaker. Participant Eleven stated that she prefers to refer to a native Spanish speaker for more complex diagnostic issues especially when a high degree of parental engagement is required to treat the problem with which her young client presents. When asked what circumstances might lead her to consider a transfer, she replied,

Certain disorders where, for me to assess it clinically in English is difficult, and therefore, in Spanish, I would be afraid that I wouldn't have the language to ask the right questions. So, um, some of the very difficult conduct behavior- not because I can't talk about the conduct, but because the treatment really needs to hit home. You know, for conduct [disorder] and oppositional [defiant disorder], you know, if that's all there is, we really need to get the parents involved in the treatment.

Participant Six related that while she rarely transfers Spanish-speaking clients in her care, she did recently decide to transfer a case with a particularly urgent diagnostic issue. Of this decision, she explained,

In a crisis it felt more urgent, and frankly, it takes more time, going- seeing a Spanish speaker is a slower conversation for me. I mean, I have to think about what I'm saying, I might- one or the other of us might have to repeat ourselves a number of times, so taking time to attend to the communication, um, eats up a chunk of what already a small- a short session anyway. And, in a crisis, if I feel like I don't have the luxury of figuring- I don't have the luxury of that kind of time. It needs to be resolved and moved forward more quickly. You know, that was when I transferred the person.

Participant Four indicated that there has been a development in his thoughts about client and therapist matching over the course of his career. He reflected,

I think that, when I first started, I used to think it doesn't matter who I am or where I'm from, I can work with anyone. I no longer believe that... It's easier to see with man/woman, because I think for myself, when I go to therapy, would I rather have a man or a woman? And at first I had a woman, and then I thought, "Ah, I think I'll choose a man. As a male." And so, I've learned that those issues do make a difference. And I just think maybe I have to work a little bit harder, then, to build a rapport, but I think it can, absolutely, be done.

For this participant, some time working in the field gave him some humility around the limits of his capacity to treat every client, along with an understanding of some of the work required to achieve rapport across differences in identity.

One participant, Participant Three, indicated that he never thought about transferring a case to a Latino/a provider. He explained, "No, I've never, because I feel

so connected, bonded, with Latin America, I've never considered that I- someone else could make better contact than myself.” He later elaborated,

I never considered that anybody could handle a Latin American better than myself, because- for one thing, is that I've lived in this area of Central America, so that's where I feel more comfortable, although most of the clients are Mexican, not from Latin America- uh, Central America. So most of the social workers here, Spanish-speaking, their roots are Latin America, but they have grown up here.

For this participant, because he had spent more time living in Latin America than many of his Latino/a colleagues, he did not think that a Latino/a colleague would be more better able to treat any case than he.

In understanding the range of decisions that participant make around referral to native Spanish-speaking clinicians, and the reasons for these decisions, it is again useful to consider how Spanish-language fluency impacts participants' decision-making. The participants who stated that they would prefer to refer most or all of their Spanish-speaking clients to native Spanish-speaking providers were those with lower levels of fluency in Spanish. Diagnostic and language comprehension issues were also more of concern to less fluent clinicians. Participant with higher levels of fluency in Spanish focused more on cultural factors that might impact the therapy relationship. They also focused more on which clients might prefer a Latino/a provider, rather than which clients they as clinicians felt unqualified to serve. The sole participant who stated that he would never think to transfer a case to a native Spanish-speaking, Latino/a provider, was a participant with a high level of fluency who had spent the most amount of time living in Latin America of all the participants. Thus, it seems that the more fluent the participants

are in Spanish, the larger the range of client profiles and presentations they feel equipped to serve, and the more types of therapy that they feel equipped to provide.

Advantages of Whiteness in Spanish language work

After exploring instances in which they felt that a Latino/a clinician might be a better fit for a client, participants were asked if they had ever thought that their being White was advantageous in their treatment of a Spanish-speaking clients. Participants generally indicated that their Whiteness was rarely or never advantageous to them. Participant Four answered, “My gut on that answer is, no.” Participant Three stated that he does not feel that his Whiteness is advantageous because he feels more identified with Latino/as than with Whites, and empathizes with Latino/as in their resentment towards White people. He explained, referring to a particular case,

I would say no, because I feel with them. If I would go with them, say this woman, I can understand how she is fearful of the Caucasians, ruling, authority people in her life, but I would feel with her more than see that I'm at an advantage because I am superior in any way or something like that.

Participant Seven said, of her Whiteness,

Actually, mostly it's been a negative. Um, I mean, I guess, just in terms of, yeah, I'm having a really hard time, like, thinking of ways that it's advantageous... mostly, I feel like my Whiteness interferes with my ability to connect.

For several participants, while they did not view their Whiteness as being advantageous, they took care to note that this does not mean that as a person or as a clinician, they might not have been a good match for a particular client, or even, a better match than some other colleagues. Participant Four explained, “It doesn't mean that I might not be suited for some clients based on who I am as a person, and I mean, being White is part of that.” Participant Eleven said, similarly,

I think working with me is an advantage sometimes, that I am a decent clinician... I think that I do provide good services and I am a compassionate person, so I don't think that working with me is necessarily a disadvantage, but I think that being White has never been advantageous.

For those participants who did name situations or clients for whom their Whiteness might be advantageous, they mentioned a range of circumstances in which this might be the case. Several participants noted that cultural difference between them and their client could be helpful, both in reducing concerns around confidentiality for the client, and because the client may come into treatment looking for a different perspective than what is offered within their community. Participant Two noted, of her Spanish-speaking clients, "They want another perspective. It isn't always what they might have always heard. So it seems that having a little bit of distance can be helpful." She gave the following example of a case in which her cultural distance from a client gave her a different clinical perspective:

There's a whole culture around menstruation, and what you do about it. Do you use a tampon and take an Advil, and like, go to your soccer practice? Or do you, like, stay at home, you know, and be precious, you know, so what do you do about that as a therapist with a twelve-year-old client? Do you suggest that there's an alternative and she could think about that? Or do you just respect that, of course, (*laughing*) you're going to miss your session, every once a month, when you have your period?

Participant One stated that her Whiteness seems to be advantageous "when it seemed as if they really preferred to have someone separate and outside." Participant Thirteen said, "Sometimes somebody says, 'You know, I just would rather see somebody that it's not going to get back to my community. You don't know my community (*laughing*).'" Participant Two understands cultural distance as being perceived of by clients as either positive or negative, depending on the circumstances. She stated,

Sometimes, people have an easier time coming to someone who's outside their culture, because they feel like, well, you're not going to judge me in the same way as somebody within my own culture. Or, they feel like, she's not going to understand me because she's not in my culture. So, you know, it can kind of go either way.

Participant Thirteen recalled that in a previous job, "Every once in a while, my [Latino/a] colleagues would come and say sometimes people would want to see someone not from their community, their perceived community."

Participant Ten noted that in one case in particular, her cultural distance from a client who she was seeing gave her a perspective that was different from a Latina colleague with whom she consulted, and yielded a good outcome for the client. She made a decision to speak with a young client separately from his mother, in English, when he was insisting on speaking English in the treatment. She explained,

I was talking about the case with my [Latina] colleague, and, you know, I could get from what she was saying, the reaction, I think- I don't want to be- I don't want to generalize culturally, but there's a sense of, like, kids need to respect you, and there's so much sacrifice that goes into raising your kids, and she would have handled the situation by, well, make him speak Spanish. That's so disrespectful. You know what I mean? And she would have just sat there with the family unit intact and done the whole thing in Spanish. And, um, I don't- in that case, I don't think she would have had as good of an outcome. Because this kid really opened up to me about a lot of things- nothing major, but even small things about what he wants to do when he grows up, what his hopes are, if he gets bad grades, what that means, and some like, conflict resolution things that we talked about, and I asked him, "Oh, have you ever talked to your mom about this stuff?" "No."

It seems that having a perspective that is different from the client's perspective may be useful, at times, in the clinical encounter. However, there is some question as to whether this can also be achieved with a Latino/a clinician. Participant One pointed out that clients' perception that a White clinician will have an "outside" perspective, more than a

Latino/a clinician, may be more a pre-conception, since all mental health professionals have clinical training that provides them with a unique perspective. She said,

I can't say that had [clients] had a Spanish-speaking clinician or, um, a non-White Spanish-speaking clinician that they wouldn't have had that experience too, because I think some of it was just accessing a professional service for the first time.

Participant Nine uses her Whiteness and belonging to the dominant culture as a stance from which to explain to parents certain elements of the dominant culture in the United States to which their children are acculturating. She described,

I do use myself as a White person to, ah, to try to help, especially with children, um, who may be struggling with their parents' expectations, um, for them to behave in a certain way, um, go in a certain direction, and by trying to help the parents understand, this is what this culture does, or even, this is what White people do, I'm very comfortable, um, being out there, and trying to explain some of the cultural, um, norms, say, and I might even just refer to White people, say, um, if I'm trying to maybe even have a little bit of a sense of humor, about, "Well, I know, in Mexico, it's typical for families to", you know, "do things together on all holidays, and for children to never go spend the night at, you know, somebody else's house, but in this culture", even saying it, or, "as White people, we do this strange thing where kids have sleepovers at strangers' houses, or they go off to summer camp, and that's just what people do here." So I may be even exaggerating, that this is what everybody does, but I'm trying to help them understand what the dominant culture often does.

Participant Six wondered whether, because she puts a lot of effort into speaking Spanish, and her struggle and vulnerability are visible to the client, the client may benefit in some way. She explained,

I think there's a lot that gets said in there that could very well land positively on people, like, I'm, you know, like starting a conversation saying, "I'm not perfect at this; I'm concerned about that; I want you to have what's best for you; you have choices here; your feedback's important to me; your comfort is more important than mine; your perceptions are more important than mine"; I mean, sort of, all of that, um, and then, you know, what's implicit, which is that I'm trying really hard. I'm trying really hard, I think very well could mean a lot to people. Well, it might. And especially to people who aren't, probably, who maybe often feel

marginalized and don't experience efforts like that... and maybe don't experience the sense of agency that I'm suggesting.

It is possible that there may be some healing for the client in witnessing the depth of the clinician's effort and caring.

Clients' internalized prejudices may lead them to prefer a White clinician over a Latino/a clinician. Participant Eight stated that clients from Mexico's capital district, referred to as El Distrito Federal (D.F.), tend to hold certain stereotypes of Whiteness that may lead them to more highly value a White clinician. She explained,

Sometimes I have the sense when people are more status-oriented that, um, they listen to professionals more, I mean, doctors, lawyers, whatever. Sometimes [Whiteness] might make a difference because of the illusion of- I don't know if it's power or knowledge. But, um, I don't really know... There are some people who specifically come from D.F. who are a little bit- they call themselves a little bit above... And they definitely come with an attitude.

Participant Thirteen also noted that Latino/as may make positive projections on White clinicians. He noted, "There may sometimes be that perception, that somebody who is Caucasian must be smarter, or better." Participant Eleven noted that White native Spanish speakers of Spanish origin might prefer to see a White clinician. She explained that the only instance where she thinks that her Whiteness may be an advantage in her treatment of a native Spanish speaker is,

When I work with Spanish- people from Spain who were very White, European, and they classify themselves as European on the form, so. But, I still thought that being White, from my perspective, it was not as helpful as... now, who knows? Maybe if a Mexican colleague were working with them it would have been an issue. I have no- I don't know. But in no way do I think that's ever been advantageous.

Here, the participant separated out the client's preference, possibly influenced by racism, from what might be clinically advantageous in treatment.

While some participants mentioned that their Whiteness might encourage positive projections, other participants noted that their Whiteness allowed them to avoid negative projections that Latino/a clients may place on Latino/a clinicians. Participant Seven considered, “If I were a Latina clinician, there might be a sense of, you know, you're part of the system, and crossed over, and, you know, there might be some issues around that, so I avoid that.” Participant Nine explained,

Sometimes I think that a particular population's own racism, if you want to put it that way, you know, perhaps they have a stereotype belief that they were, you know, raised to believe, such as Latinos are not very smart, if they were, unfortunately, raised with these kinds of ideas.

Further study would be necessary to determine how common these projections are, and how much they affect the course of treatment with culturally matched client/clinician dyads.

Participant Five explained that she is able to use her difficulties with the Spanish language as an opening to ask clients for help and highlight their expertise, thus creating more of a partnering relationship than an authoritarian one. She explained,

For kids and families who kind of feel like, I'm coming to you for help, and you're the professional, and I'm kind of in this one-up position, to be able to use that- and you have to do that consciously; it doesn't necessarily happen automatically, but to be able to say, you know, "Help me out here", like, "Spanish isn't my first language and it is yours, and you're the expert here." Or, the cultural questions. You know, we're going to be talking about your experience in Honduras, and I've never been there, so you might have to give me some more information, and give me a picture of what it was like. I feel like that has often been really helpful, to kind of, like, let the client and family feel a little bit more even with me. It's like they have some power and knowledge that I don't have.

Participant Four explained his being bilingual served as an important model for some of his clients who were struggling with maintaining a bilingual, bicultural identity. He said,

Well, I guess with kids, so there might be a time, and again, my gut is still no, but maybe there's a time with kids where, because often the kids don't want to speak Spanish, even though that's all the parents speak, and so maybe I could model the facility of going back and forth with both languages.

He noted that almost all native Spanish-speaking clinicians working in the United States are also fluent in English, and they may be even better equipped to role model a facility in switching between English and Spanish.

In total, most clinicians felt that their Whiteness was never or rarely advantageous in their treatment of a Spanish-speaking client. The most commonly mentioned advantage of White identity was that it allowed for more cultural distance between the client and the clinician, which the client might see as advantageous, and may also be advantageous clinically if used thoughtfully. Another common response was that the cultural and language difference shifted the power balance towards the client, who is the expert in his or her own culture and native language. Other common advantages came as the result of race-based projections from the clients that arose early in treatment. These may or may not continue to impact the treatment as the client becomes more acquainted with the clinician on an individual level. Importantly, responses to this question do not group according to clinicians' level of fluency in Spanish, or other identifiable factors. Responses were, in fact, more uniform, with all clinicians responding that their Whiteness was generally disadvantageous in their treatment of Latino/a Spanish speakers, even when they did note some circumstances in which this may not be the case.

Supervisory and colleague responses to participants

Participants were asked how their supervisor and colleagues respond to them as Spanish-language service providers. Most participants reported that, on the whole, almost all colleagues and supervisors respond positively to their skills in Spanish. Participant Eleven said, “It’s definitely seen as an asset in the department.” Participant Twelve said that she thinks she’s heard “directors really bragging about Spanish-speaking clinicians, because everyone wants to have them.” She said,

From the supervisors, and even peers sometimes, there’s this idea that we have something a little bit extra that people don’t have, which is literally is true, we have language that they don’t. But there’s some kind of, kind of, a respect.

Participant Eleven even noted that as a Spanish-speaking provider, her skills are so valued that she is solicited for other job opportunities with her own agency, even though she has already committed to her particular position.

Positive feedback around their provision of Spanish language services comes in many forms for the participants. Participant Six noted that her supervisor formally acknowledges her provision of Spanish-language services in her evaluation. She stated,

My supervisor makes a point of mentioning in my evaluation that I provide Spanish-speaking services, and highlights it in a way that certainly acknowledges that I’m making a contribution, um, and providing a service that, you know, not everybody here provides. So it gets acknowledged.

Participant Seven noted that positive feedback from colleagues also comes rather spontaneously. She described an example of such:

Today, I was going to this [meeting], and the father is a monolingual Spanish speaker, and the school personnel are not, in general, except for the outreach coordinator, and, so, ah, they were trying to decide a date to reschedule, and um, and so, the dad was being largely ignored, so I jumped in a couple times, you know, just to make sure he kind of knew what we were talking about, what was

going on, you know, and running dates by him, and stuff like that. And the Director of Special Education said, "Wow, I'm so glad you speak Spanish!"

Some participants mentioned that there were certain people or groups within their agency who, for particular reasons, were especially appreciative of the participants' Spanish language skills. Participant Four noted that his supervisor, who is Latina but learned Spanish as an adult, shares a special empathy with the participant around challenges of providing services in one's second language. He reflected, "I think maybe we connect on that level of being newer Spanish speakers, and she I think appreciates that and can understand having a difficult time communicating in Spanish." Several participants noted that the colleagues from whom they received referrals were especially appreciative of the participants' Spanish-language skills, because it makes the referral process easier. Participant Seven noted that the colleague who gives her referrals appreciates the flexibility and convenience that her Spanish language skills allow. Participant Six noted that because she is a member both of the Spanish language providers' team and the general Diversity Committee in her agency, both groups appreciate her work to act as conduit between the two.

Participant Thirteen indicated that at his agency of employment, while Spanish-speaking clinicians are generally commended by supervisory staff for their work, they are not always given the structural support or compensation that might indicate a deeper level of appreciation. He explained,

For example, during the intake process, um, we often did not have a Spanish speaking clinician available, initially, in the- the team of people who triaged the clients when they called. So...initially, the Spanish speakers carried pagers with us, and we had to interrupt sessions with our other clients when we had to take a crisis call or a triage call... we had to have those sort of interruptions... So that was something that we had to help our supervisors understand.

He went on to elaborate,

I think that one issue is that I and my colleagues have always felt at *agency name deleted* like, this is a pretty special skill, and they pay me 50 cents extra an hour? Come on! That's really not feeling very appreciated in terms of the efforts we put in. And especially when we're providing extra services that other people aren't being asked to, like carrying a pager to deal with crises. Um, so that- that was frustrating, and we've never really been able to negotiate a better, ah, monetary compensation, but, ah, I think there's certainly a lot of just kind of, "Good job, *atta boy*."

Several participants were surprised that, during the hiring process and as they transitioned into doing Spanish-language work, their Spanish language skills were never evaluated or even heard by their agencies of employment. Participant Ten reflected,

Well, I was actually surprised in the interview process, they never once made me speak Spanish. I couldn't believe that. Yeah. They were like, "Well, you lived in Peru", and I was like, "Lots of people live in other countries and they do not learn, you know, not learn the language." But I think at that point, you know... we have a really small department, and they're having a really hard time filling bilingual social work Masters level positions, so, I guess they were just like, "Ok."

She went on to say that she wishes that her hirers had asked her to speak Spanish during the interview process, and feels they should have. She was worried that the agency might have expected her to have native-level fluency, and was anxious as she began her employment. She reflected, "I just kind of felt some pressure, where at least, if they heard it maybe during the interview process, it would have been like, 'Well, ok, you know what you're getting.'" Participant Seven reported a similar experience. She said, of her Spanish language skills,

No one checked. I- they asked me if I could speak- well, it was on my resume that I could speak Spanish, and they've taken that for granted. Like, no one has ever tried to test me, or, I mean, there's been no- I could speak a few halting words of Spanish and they would have no idea.

She went on to explain that, while it is convenient that she has not needed to prove her skills, it would also be beneficial to have more someone watching her more closely and providing more support and consultation. Participant Twelve explained that her supervisor seems to assume that her proficiency in Spanish is high and her ability to provide clinical services in Spanish is good, based on their conversations about Spanish-speaking cases. She noted, “So, I think I’ve gotten positive [feedback], but you can’t measure it so much, because no one’s listening to me speaking in Spanish (*laughing*).” She also reported that no one asked her to speak Spanish during her hiring process. Of this, she said, “Sometimes that’s nice, they trust you. But they should take it seriously.”

Of those participants who had an opportunity to work with Latino/a supervisors, many described these supervisors as very important sources of support and learning in their development as Spanish-speaking clinicians. Participant Five reflected, “My supervisor is Latino, um, and he, I feel like is, you know, totally accepting, you know, thinks my Spanish is great, and, you know, I don't feel like he would treat me any differently if I were Latina.” Participant Two said,

In my training I had two Latina supervisors. And I think they were a really critical part of my, you know, development as a therapist. They were encouraging, and educational, you know, in giving me lots of information of cultural relevance to the clients when I worked with them.

She went on to note some cultural differences in supervision style between these Latina supervisors and non-Latino/a supervisors with whom she has worked. Participant Two described her Latina supervisors as warm, personal, and less rigid about boundaries than their White supervisors. She reflected, of her Latina supervisors,

They were very maternal... [My first supervisor] was very maternal, and very, I mean, she kept in touch with me and invited me to her house. That was the other

thing- there's always the joke about the boundaries. You know, with the Latino clinician, and this talk about- you know, just much more open in a lot of ways. And the White clinicians are straight and boundaried.

This participant found her supervisors' culturally informed supervision style both useful to her as a supervisee, and informative in terms of culturally patterns of relationships.

Several of those participants who were not working with a Latino/a supervisor indicated that they used their Latino/a colleagues for consultation on issues that their supervisor could not adequately address. Participant Thirteen explained,

I saw a lady at one point who described a, ah, a situation of *brujería* that she was perceiving, of witchcraft that she was given, that somebody had done against her, and my supervisor was of no help with that, but I was able to call up a colleague who actually, um, did a lot of work in that particular area, who was able to help me out.

He noted that when he has approached Latino/a colleagues for consultation, he always finds that these interactions go very well. Of his experiences of seeking consultation in this form, he reflected that he feels "...absolutely no discomfort with that on either of our parts that I can think of over many, many years. I'm grateful for that." Participant Six noted that her Latino/a colleagues are very accepting and appreciative of her as a Spanish-language provider, and when they note differences between her and them, it actually reflects positively on her. She explained,

The Spanish speaking providers, I feel, express a good amount of appreciation, and treat me like one of their equals, and to the extent that I'm not, you know, are only sort of grateful that I'm participating at all, I think.

She went on to explain that her Latino/a colleagues understand that they have cultural knowledge that she does not have, in spite of their shared linguistic knowledge. These differences do affect how they relate, but in a positive way. This participant finds that

being aware of and curious about these differences is important to her functioning as a clinician. She explained, of her Latino/a colleagues,

They've gone to *quinceañeras*, and, you know, I don't know if I ever have. I didn't grow up going to a Catholic church and they probably did, so, I don't have any illusions that I understand exactly what it's like to be in that culture. Um, but at least I'm aware enough to know that I don't know that, and to be curious... I don't think I know as much as my colleagues do about what it's like, and they are respectful to me, but I know they know I don't know exactly what it's like.

Several participants indicated that their Latino/a colleagues' choice to speak with them in English or in Spanish was an important indicator to how their colleagues thought about and responded to them. Participant Ten indicated that she is pleased that her native Spanish-speaking colleagues talk to her casually in Spanish, and sees this as a sign of acceptance. She reflected,

I've noticed in other, um, situations in the US, when I try to speak Spanish with native speakers of Spanish they respond in English, um, more often they respond in English, and I like that at this clinic, you know, we have a conversation in Spanish about, just talking, you know? And so, that makes me feel more, I guess, kind of accepted, and part of the culture. Like, my language is not just for when I go behind a closed door at speak with a client speaking Spanish, but it can be, you know, a mix. It's not that it's a separate identity, like, I only speak Spanish when I provide Spanish services, but my speaking responsibility is just part of who I am, and I like talking in the office.

Participant Eight also described responses to her by Latina colleagues positively, reflecting, "They're great. Really, really positive. Really, really encouraging." For this participant, her colleagues' use of Spanish for casual conversation with her also indicates connection, and she and her colleagues are able to be mutually supportive to each other around issues of language. She said of her Latina colleagues,

They say, "Oh, yeah, you're doing really well", you know, we speak Spanish in the office, and we share Spanish jokes, and if I don't get it, they explain it to me, and, you know, we do translation together- and, you know, sometimes my

Spanish is actually better than theirs, but their colloquial Spanish is way, way, way better than mine. So, um, it is really a close team, really supportive.

Conversely, Participant Seven noted that in her work environment, while Latino/a colleagues seem to be glad that she speaks Spanish, they do not speak to her casually in Spanish. Paralleling feelings from participants who noted that casual office conversation in Spanish leads them to feel more connected with their Latino/a colleagues, this, for Participant Seven, indicated a level of separation.

Numerous participants reported some challenges in connecting with Latino/a colleagues that seemed to have something to do with cultural and linguistic differences. Participant Four noted that connecting with Latino/a staff in his agency has been more of a challenge for him than connecting with Spanish-speaking clients. He said,

It's been easier for me to connect to the Spanish-speaking clients [than] the Spanish-speaking staff members, and so it's always been much harder for me. ...For a while it was hard at the beginning, for staff much more so than the clients. Clients are much more forgiving, and I was probably acting different also.

He went on to reflect that when he initially entered his agency of employment, he felt a divide between himself and his Latino/a colleagues. He explained,

In the beginning there was some issue. I don't know what. I think there was some resentment, and I felt it, whether or not I fully created it in my mind. I think there was some, there was some issue of, what are you doing with my clients, with my culture. And especially because it's not just, I got in and I speak the language. I have an appreciation for lots of aspects of the culture. Liking the food, and liking the music. And I thought about it a lot in the beginning, and I think there was just some conflicts between me and especially one person who was a recent immigrant, and her English wasn't great, so it could have been some of her own issues. But like, here I am, providing services in Spanish, and she's coming here unable to provide services in English, and so there could have been, I think a lot of them were her issues. But nonetheless, it was an issue and I did, still, I know, I would be lying if I said it's not an issue, people sometimes question my motivations for working in this community. Now hopefully, after a while they realize that I genuinely just like the work that I do...

Participant Six described some disagreement in an exchange with a Latino colleague to whom she transferred a Spanish language case that she did not feel qualified to manage based on its complexity. She explained, of her colleague,

He very diplomatically, very nicely, said, you know, "You're one of the [Spanish-speaking providers'] group, and it felt a little bit uncomfortable to me that you would", sort of, he didn't use the word "unload", but that's, I think it felt like that to him, that I was transferring. And, we had a conversation about it. I said, "I get that. You know, and I feel badly about this." And he said, "You know, I'd like you to be able to pull, sort of, your weight. You are a member of this group." And I said, "Well, I would like to too." And, you know, he said, "I know you think that you don't think your skills are adequate. I suspect that they're better than you think they are. I'm not sure you give yourself enough credit." Which may or may not be true. I don't know. But I also know I'm not fluent, and I know when I'm not understanding things, and that, you know, I'm realistic in my assessment of myself. Um, and I know, at the very least, subjectively, when I feel like I'm over my head. And, uh, and I may well be... and he made the point of just throwing in, he said, you know, "There are times even still when I don't necessarily understand everything in English. But I don't have the luxury, of, um, you know, saying I don't think I'm skillful enough to do that. And, also, earlier on, in my experiences as an English speaking person in this country, I didn't always understand, but I pushed myself." And he said, "I just, you know, encourage you to think about pushing yourself a little bit." And, um, so it was a very good conversation, and it wasn't adversarial or acrimonious, and, you know, we left with, I think, a shared understanding, even if he didn't agree with it, of what had happened.

This exchange speaks to the complexity of interactions between White and Latino/a Spanish-speaking clinicians, where issues of personal history and identity, clinical skills and confidence, and systematic equality and discrimination can converge. For Participant Six, this interaction brought up feelings of discomfort, shame, lack of confidence, confusion, and overwhelm. This exchange at once provided her with information about how her colleague responded to her as a Spanish language service provider, and raised new questions for her about this role.

Participant Five also talked about a complex response by a Latina colleague, where the colleague seemed disappointed that their employing agency hires a lot of White Spanish speakers, but then also seems to connect with the participant and other White Spanish speakers on a personal level. She described the situation as follows:

We do have, actually, somebody I'm really close to here, a Latina attorney... she's always talking about how our agency hires White girls who speak Spanish. Um, and we, we- it's true that we have had several, but we also have as many Latinos who speak Spanish, and aim for that, I mean, that's usually preferred, that somebody can be bicultural as well. But, um, you know, I think they also take whoever they think is going to be the best fit for the agency, and so, what's funny about it with her is, you know, she's somebody where race is an issue in everything, and it comes up in everything, um, and I think she has a lot of resentment around it. But what's funny is, she's had issues with most of the Latinos who have worked here, and has really adored [White Spanish speakers]... I think we're her favorite people to work with, um, so yeah, it's kind of a funny dynamic where it's a frustration- a larger frustration for her of, you know, "Why is it that we're hiring all these, you know, White people who speak Spanish?", and, you know, White people in general, and then, ultimately, like, really liking those people and feeling like they do good work, and not always feeling that way about her Latino co-workers.

Participant Five goes on to explain that she sees the issue as a large systemic one, where not enough Latino/as are getting their legal and social work degrees, while her colleague locates the problem more in the agency. She says, "It's frustrating. Because I feel like, you know, I get it that this is a larger social issue, but I don't feel like I shouldn't have been hired here because I'm a White person."

Participant Eleven talked about an experience of a Latina colleague making a condescending comment about White Spanish speakers in her presence. She recalled,

Only one time was I insulted by a practicum student. It was last year, I think. And I don't think she realized she was insulting me until she said it. She said, "Oh, G-d, you know, I can't stand hearing the accents of", you know... "White people who, you know, speak Spanish," and I just looked at her and said, "Sorry. Not much we can do." And she kind of blanched, you know, I could see, and she's like, "Oh, no", and I'm just like, you know, "No problem." I wasn't going to

get into anything. But that was really- I felt so bad, because that's something that I really am aware of and conscious of. I work hard to not have such a horrible accent (*laughing*)... I felt very ashamed, and I felt like, maybe I shouldn't be doing this.

It seems that many participants highly value their Latino/a colleagues' perceptions of their Spanish language work, and that this is an important source of their confidence that they are able to provide good services in Spanish. When their Latino/a colleagues question or insult their skills, therefore, or the deservedness of their employment, they feel this as particularly hurtful and challenging to their identities as Spanish-speaking clinicians.

Reported responses from non Spanish-speaking, non-Latino/a clinicians were varied and often mixed. Non-Latino/a colleagues and supervisors did serve as sources of learning for the participants around their Spanish-language work. Participant One indicated that she is able to use private consultation with a non Spanish-speaking clinician to talk about issues around Spanish language work, and she finds this useful. Participant Thirteen noted that one of the ways that his non-Latino/a supervisors have been useful to him is in acknowledging the limits of their own expertise, and allowing him to access consultation from Latino/a colleagues when appropriate. He explained that when his supervisor cannot provide the consultation that he needs,

I can walk down the hallway and talk to someone who really knows the culture, or talk on the phone with other people I know, and, you know, I'm comfortable with that. That's a reasonable way to deal with that lack of support that's there, just because [the supervisor is] not a native speaker. All we can do is know that we might have a blind spot there, and try to get it somewhere else.

Participant Two described more mixed responses from colleagues who don't speak Spanish, reflecting, "I think, um, there can be envy....I mean, um, admiration, envy,

annoyance.” She added that she was not very clear on these feelings because they were not usually communicated directly. Participant Five indicated that some of her White colleagues wish that they had the skills that she does, also, perhaps, reflecting some envy. She stated,

I've had, you know, everything from people being, you know, really positive, and you know, “That's so amazing”, and “How is your Spanish so good?”, and asking a lot of those questions, especially with other, you know, White Spanish speakers who are, kind of, working on their Spanish and maybe don't speak as well as I do. Just like, you know, appreciation, and desire to understand, “What did you do?”, and, “What can I do?”

Participant Twelve reflected that responses from White non-Spanish speakers may also include regret at not having acquired this important skill. She explained,

I've had some people say, “G-d, why didn't I learn Spanish? Blah, blah blah.” But, um, I think there is, I think there's some jealousy in that, because, um, it's talked about a little bit, like I said, within agencies, and also, when cases come out and they're Spanish speaking, I think there's some awareness that there's some importance to that.

Several participants, including Participants Six and Seven, noted that some of their colleagues may not know that they speak Spanish.

Several participants indicated that they are sometimes asked by non Spanish-speaking providers to provide interpretation services. Participant Twelve indicated that she finds it validating in her identity as a Spanish-language service provider to be approached for consultation around issues of Spanish language work. She talked of one incident where this was true:

I was sitting in a room, and there was a woman, *name deleted*, who is Mexican, so her first language, I think, is Spanish, and then English, and then the person knew that we both spoke Spanish, and came in and sat next to Gabby and asked- started asking her a question, Spanish stuff. I don't remember if it was history, or something, and *name deleted* started talking, and then she said, “You could ask *participant's name deleted*, too!” (*laughing*).

She went on to explain that she felt “invisible” when her colleague approached her Mexican American colleague, and affirmed and connected to the Mexican American colleague when that colleague pointed out that the participant could also be a resource. Participant Three also has the experience of non-Latino/a colleagues using him for consultation in working with Latino/a families. He also enjoys being in this position, explaining,

They, they don't have an understanding, you see, even like [colleague's name deleted]. But she'll, she'll reach out, as soon as she gets in contact... But they'll look for [consultation]- “Can you help me out with this situation?”... They know that there's something that can be offered to people but they just don't know how to do it, at that moment.

Participant Six also has the experience of being asked for help with Spanish language interpretation, and she also is receptive to being used in this way. She explained, “I'm happy to be helpful and useful... If my door is open, I'm happy to be helpful, you know, in any way.” Participant Nine described a similar willingness and even enjoyment of helping out with interpreting for a phone call as necessary, or guiding a lost Spanish-speaking client to the correct location.

One participant, Participant Thirteen, had more mixed feelings about being used as an interpreter for non Spanish-speaking colleagues, especially psychiatrists. When asked of feelings on serving as an interpreter for other providers, he explained,

It's definitely one of those tricky ones... we're getting into some of those medical areas, and... certainly, it happened many times before I was more formally trained as being a bilingual interpreter, and that- that can feel uncomfortable, and there have been times when I've had to say, “Look, I don't know, you know, you talked about medication side effects- I don't know how to say that.” Or, “I'm not sure what the word you just used... can you show me where that is, look that up in the dictionary, make sure that I'm not getting that wrong.” ... It's a wonderful service to be able to provide if I could do it well.

While he didn't mind being asked to provide interpretation services, he was concerned that he may not be qualified to provide this service.

Several participants mentioned finding support and empathy from other White Spanish speakers. Participant Five explained that she was fortunate to find this empathy during the interview process for her current job. She said,

My second interview was with the managing attorney and the executive director, and the managing attorney is a White Spanish speaker, and when I said those things about, you know, the advantages of being a White or non-Latino Spanish speaker, she totally got it, and had that same experience, and, you know, being able to, kind of, use it to her advantage.

Participant Eleven noted that she wishes that she had more contact with other White Spanish speakers, and suggested that this contact may boost her self-confidence around her qualification to provide services in Spanish. She explained,

My confidence level is lower especially when I'm surrounded by Spanish-speaking people. I think if I were with other White people who spoke Spanish, I'd feel much more confident. But because I'm with Spanish speakers, you know, then I think, "Oh, I won't be able to speak as well as they do", and I don't, so my confidence level dips.

While White Spanish speakers may be an important source of support, Participant Eleven also notes some discomfort in observing the over-confidence, or even "cockiness", of some of her White Spanish-speaking peers, and being more aware of their limitations and how they are received by Latino/as than they may be. She explained,

There are Spanish speakers- White Spanish speakers in my office- who don't speak as well as I do. I can hear it! And they're so confident. And I think, "Wow", you know, I don't want to be cocky- that's just not me. And I also feel- it's one thing to be confident, and it's another to be cocky... I don't know if that's just a lack of confidence, like, I should be like that too, but they open their mouths and I can't believe what comes out. And then I also know that my Spanish-speaking friends... they're laughing. You know? So I think part of it's that I see

that they make fun of White people who speak Spanish, and I don't want to be one of those people.

It seems that Participant Eleven's social proximity to Latino/a communities led her to see less fluent Spanish speakers more critically, and perhaps, want to distance herself from those speakers.

Participant Twelve reported that non-Latino/a Spanish-speaking colleagues who are newer to this type of work may look to her as a mentor. She explained,

There's a new woman who came in who is Caucasian and is speaking Spanish, and, um, she was- she was nervous and kind of upset that she had a supervision where her supervisor, who happens to be my supervisor, had kind of questioned her Spanish speaking abilities, which first, made no sense to me, because [our supervisor] doesn't speak Spanish, so how would you know? But, the new person said that she brought something up, she was vulnerable, she said, "I was in a home, and I started to say this, and then I didn't understand", or whatever. Which I think is wonderful. I mean, that's what [supervision] is for. And this supervisor happens to be- can be really difficult. And, um, so she started kind of doubting her, and then she came to me, the new clinician, and she said, "Is there room for some forgiveness here?" She said, "I just feel really shaky."

The participant was able to be supportive to her colleague, and used this as an opportunity to reflect upon her own supervisory experience and learning process as a non-native Spanish-speaking clinician.

In total, most participants reported that their reception as Spanish speakers by supervisors and colleagues was generally positive. Latino/a supervisors and colleagues were important sources of learning for the participants, and were gracious around being used for consultation. Likewise, participants were gracious around providing consultation and/or interpretation for non-Latino/a colleagues when they felt qualified to do so. Non-Latino/a colleagues were grateful for these services, and, in general, for the participants' contributions. However, participants also noted that some non-Latino/a

colleagues responded with jealousy, and that some non-Latino/a colleagues in supervisory or administrative positions could not or did not provide the clinical and/or administrative support for Spanish language services that would have been most useful. Those participants who did receive more critical feedback from supervisors and/or colleagues usually reported an isolated incident of receiving this feedback, but noted that these exchanges were difficult and challenging ones that impacted the clinicians' identities as Spanish language service providers. Providers who received more critical feedback had a range of levels of fluency, and worked in a range of different types of agencies. For some participants, critical feedback came from distant acquaintances, or came very early in participants' tenure in an agency, and in others, the feedback emerged in the context of closer, more trusting relationships. In most cases, participants understood more critical feedback as at least partially rooted in larger agency and social problems, and were able to understand and learn from the exchanges as such. For this question, there was no evident correlation between Spanish language fluency and how participants' supervisors and colleagues responded to them.

Quality differences in English language and Spanish language service provision

Participants were asked if they feel that there are differences in the quality of the services that they provide in English versus in Spanish, and if so, where in their work these differences are most evident. Many participants indicated that they did feel that the services that they provide in English are some degree better than the services they provide in Spanish. Participant Thirteen reflected,

I don't know, I mean, my gut wants to say I might be a little better in English. You know, I don't want to say that, because, I want to work in Spanish, but if I want to be completely honest, I don't know, that's a good question.

He added that he would like to have more objective information that would allow him to have a clearer sense of the answer to this question. Participant Nine, when asked whether there are quality differences between the English and Spanish language services she provides, responded, “One hundred percent yes.” She also reflected that her feelings about her work in Spanish can vary by the session. She said,

I just know, sometimes I will, you know, leave an appointment or something and feel like, you know, things went well enough, and I accomplished what I wanted to, and I feel like the parents had a good experience, and other times I'll feel like, I don't know if they felt comfortable, you know, if they felt like I was able to speak as well, or understand them as well.

Participant Eleven noted that she continues to feel conflict and frustration in the limits of her Spanish language skills, and how this impacts her ability to provide services. She explained,

I don't want to speak well enough; I want to speak well (*laughing*). You know? And that's always been my struggle, people saying, "Oh, your Spanish is fine." But I don't want it to be fine! I want it to be great! But it can't be great until you high-tail it to somewhere else. And so that's- I'm always riding that, that divide.

Several participants indicated that limitations in their fluency in Spanish yielded differences in articulateness, speed, or accuracy of speech, which could result in quality differences. Participant One indicated that the precision of her speech in Spanish suffers. She explained,

I think that, because English is my first language, and I feel the most comfortable speaking in English and expressing myself, and I feel very particular and precise about my word choices in English, and can say things sometimes in much more delicate and fine-tuned ways in English than I ever could in Spanish, so I don't know if it really- I think that the service I provide is still good in Spanish, but I might not feel as satisfied in getting to the precise point I want to make, or expressing myself as- as precisely.

Participant Thirteen said, “Yeah, there’s a difference, and I think that the difference is that it’s easier for me to speak English. I’m way more articulate in English.” He went on to explain, “I’m not firing on all- again, it’s just the 95 percent. It’s just that five percent better that I could do, um, if I- if I were a native speaker. But I’m not.” Participant Six said,

I think there are differences, and it's struggling with the language. I can't think and speak as quickly, as accurately, as fluently in Spanish as I do in English. Sometimes, you know, that means going slower and not having time to say as much. Sometimes it means that there are directions that I'd like to go clinically, and I'm struggling too much with the language. You know, I may make a choice not to go there because it's hard to get the language.

She noted that she is concerned about the potential impact of the limits of her Spanish language skills. She reflected,

And it's scary. You know, when I sit down, and, you know, the work is always a very big responsibility, making risk assessments and plans and things like that, and doing it where I'm not sure I'm catching everything is scary. You know, my skills are good, and maybe I'm better even than I think I am, but that feeling of discomfort is present in a way that it's not with my English speaking patients.

Participant Ten described unfamiliarity with biological and medical terms as a specific deficit in her Spanish language skills and services. She explained,

In English I feel much more comfortable explaining biological things, and you know, serotonin, and norapenephrine, and how it works in your brain, and I don't think I quite have the skills to explain it [in Spanish] in the most satisfactory ways sometimes.

Participant Five noted, more generally, “There are just moments here and there where I think that I wish that I could have explained that one thing better.”

Participant Seven explained that in Spanish, her focus on the words leads her to focus more on process than on content than she would in English. She said,

I think because so much of my energy is focused on, "I want to understand the words coming out of your mouth", I'm not thinking as process. I'm very content, you know? ... I feel like my whole brain is, like, trying, and it doesn't really leave as much room for me to kind of sit back, and be relaxed... it's harder, too, to really focus on the interpersonal piece of it, because you know, I'm trying to, like, say the right words, and (*laughing*), you know, there's just so much more energy that goes into it, that I- I feel like I have less energy for the clinical part that I want to have, in order to provide the best services.

She went on to express concern about how language-processing difficulties may impact the flow of conversation. She explained,

If I don't know a word, and I have to kind of explain around it, and then I have to go back to where I was, and what I was talking about, I feel like I lose people sometimes, because I'm a very tangential person.

Participant Thirteen feels that group work is more of a challenge on his language skills than is individual work. He explained,

I'm so busy just trying to really listen to what the group is saying, and, um, it's harder to kind of listen and multi-task, both the listening and the speaking, in Spanish the way I can in English. Generally, when I'm working with individuals, I feel a lot better at that. Um, I find in the groups that it's much more challenging to do that language multitasking.

Several participants indicated that there is a certain level of fluency that a clinician must achieve in order to provide quality services in Spanish, and they are aware of this line and where they stand in relation to it. Participant Thirteen stated that he might have been closer to this line earlier in his career, but now feels much more comfortable and proficient at providing services in Spanish since his fluency has improved. He reflected,

In the beginning it might have been I wasn't able to do as good of a job. I don't know. But now I think since I've gotten much more comfortable, I think I can do- I can also walk out of being in a session in Spanish, and think, "Wow, that went well."

Participant Eight noted,

If I couldn't understand what they were saying at all, or they couldn't understand me, that would obviously be a very serious problem. Now, backing up from that, there are many, many things that are gonna change the interaction in a room. Particularly, not speaking the language, yeah, that's a bit of a problem. But, um, the level to which the culture truly does interfere with that kind of therapy, um, I think that needs- that needs to be examined a little bit.

For this participant, real problems with fluency would pose a major challenge to a clinician's ability to provide services in Spanish. She implies that cultural differences may be more manageable, and less of a clear deterrent from engaging in the work.

Participant Five clarified that, if she ever did seriously question whether a client was receiving services of adequate quality, she would get help. She explained, "I definitely think that, you know, if I ever feel like I'm really short-changing a client, I'll get help. I'll either refer or I'll get somebody here who speaks Spanish more fluently than I do, and get their assistance..."

In contrast to many of the other participants, Participant Three stated that he actually feels more competent in providing services in Spanish than in English. He attributed this to his familiarity with providing services in Spanish, since all of his cases include at least some Spanish-speaking family members, and to the cultural feel of providing Spanish language services. The participant explained,

I think I'm more uncomfortable in English, than in Spanish... I guess I feel more ignorant, because I'm dealing with all of these agencies in Spanish, and with Spanish, Latin America, because you have always that warm, tender, caring relationship, and even the language is just poetic instead of cut and dry, ugly, salty English, so there's something about Latin America or Spanish that's warm and comfortable.

Several participants indicated that they understand there to be differences in the services that they provide in English versus in Spanish, but hesitate to label these differences quality differences. Participant Eight said, "There are differences only in as

far as the Spanish speaking population is different from the English speaking population.” She went on to explain that many of clients she sees in English present with mental illnesses, while clients she sees in Spanish present more with environmental stress, often due to economic, housing, employment, and residency status concerns, which necessitate different kinds of interventions. Participant Twelve reflected that the process of building a therapeutic alliance may take longer with Spanish speaking clients, so the progress of the treatment may be slower. She explained,

I don't know, but I want to say things move a little bit, um, slower... I don't know if quality is the way to say it, I think it's more, um, because of those differences, there is gonna be a little bit more- there may be a little bit more wiggle room in warming up before things can take place...

She said, further, that while from an uninformed outsider's point of view, it may look like the treatment is going slower or less successfully because more time is spent building the relationship and building trust, her clinical sensibilities tell her that some treatment relationships take more time to develop, and this is simply part of what some clients need. Participant Two also indicated that it feels difficult to her to gauge quality differences. She said, “I don't know, in terms of quality- it's hard to say that one is better than the other.” She noted that certain challenges to providing services in Spanish are not present in her English language work. She said,

[English is] still my native language. And I know what every single word means. Or if I don't, I know right away that it's coming from some, you know, expression that is very specific, very personal- speech, religion, age...

However, for this participant, there is not a direct correlation between how fluent she is in each language and the quality of services that she is able to provide in that language.

Several participants noted that they sometimes wonder if a native speaker would have been able to provide a better service, or wish that they were able to provide higher quality services, but have some acceptance around the limits of what they are able to provide, and try to do the best they can within those limits. Participant Nine said, of limitations in her provision of Spanish language services, “I wish it weren't the case, but that's the way it is.” Participant Thirteen said that he sometimes wonders, “So should somebody else do it? But I’m the person who’s sitting here, so I just do my best.”

Participant One said,

I think I manage. I manage to say what I need to say, and I think, I'd like to think more often than not that I'm being understood. I just might not feel I get the precision that I want.

Many participants who did indicate some quality differences in the services they provide in Spanish versus in English reflected on what drives them to continue providing these services. Participant Four indicated that he feels that he is able to provide high-quality services in Spanish, even though there may still be some quality differences in his English language versus his Spanish language skills. He explained,

I'm fairly confident and I think that it works... I have no doubt that it works in Spanish. And we have much more than just it works, anyway. So I definitely believe that it's still, you know, relationships, and getting to know each other.

Participant Eleven also indicated that, while she is aware of limitations in her Spanish language skills, she still feels that she is able to provide a good service. She said,

I'm not a fluent speaker. So sure, there would have to be a lower- it's hard to say- I don't want to say it's a lower level. A difference, I guess, is the best I can say. It's different. But it's still- I think they still walk out with the same- I still have a very good connection. I typically will say, I know what's going on with this kid, you know, as best as I can, after one day.

Some participants suggested that their strengths in other areas may compensate for weaknesses around their Spanish language skills. Participant Five noted,

I definitely have times where I feel like, you know, frustrated, you know, if it's fair that I would be adding more to this conversation if it were in English, either because I don't have the vocabulary... but, because, sort of, working with this specific population is such an interest of mine, there are times when I feel like, you know, I've learned so much about this specific work, that I may be giving services to these kids that I'm not giving to the kids who aren't, you know, aren't immigrants, who we're serving in some other way, and, you know, I do my best, but it's not what I'm focusing on. And so, like, I mean, there's maybe a trade-off there.

Participant Thirteen reflected,

I hope that the other things that I bring to the table, the experience there, and as somebody who's had pretty high member satisfaction ratings over many years, that, you know, I'm bringing something to the table even if I'm not a native speaker.

For this question of quality, one might predict that participants who are more fluent in Spanish were more confident they are able to provide services of similar quality in Spanish and in English. This is partially true. It was those clinicians with lower fluency in Spanish who most unequivocally reported that there were quality differences in their ability to provide services in Spanish versus English. Many less fluent clinicians named multiple concerns, and multiple areas in which their Spanish language services may be lower in quality than their English language services. More fluent clinicians, though, were not on the opposite end of the spectrum. Even very fluent clinicians reflected that their English language skills were still superior to their Spanish language skills, and some entertained the possibility that this may be reflected in quality differences in their clinical service provision. However, more fluent clinicians were more inclined to state that these differences in their language skills did not necessarily correlate

with differences in the quality of their service provision, or that slight quality differences did not negate their ability to provide high-quality services. The one participant who was most confident that there were not quality differences, and that, in fact, felt more comfortable providing services in Spanish than in English, was a participant with a high level of Spanish language fluency who had spent the most time living abroad of all the participants. In sum, then, while most participants reported that there may be some quality differences between their English language and Spanish language service provision, those participants who were concerned that these differences may truly compromise the quality of the services that they provide in Spanish are those who are least fluent in Spanish.

Recommendations for support and training

At the conclusion of the interviews, participants were asked what additional support or training, if any, would help them improve the quality of Spanish language services that they are able to provide. All participants responded that additional supports and training could help them improve their services, and they offered many ideas as to what those supports and trainings might look like. Participants suggested various resources and sources of support that they would like to have access to in order to improve their Spanish language skills.

Some participants suggested that it would be useful to have access to formal Spanish language training specific to their needs as clinicians. Many participants perceived that there were was little training available that really met their language learning needs. Participant Eight indicated that she would like to have more “grounded” language education, focused on colloquial speech. She suggested that the training would

need to be specific to those providing mental health services, as training directed towards physical health practitioners is not as useful. She said, of a medical Spanish program she took, “[It’s] a really good program. But it never goes to that level, you know. It’s Spanish for medical practitioners, which is more about, ‘Where does it hurt?’ And the language of therapy is way more complex than that.” Participant Nine agreed that she would like Spanish language training specific to her role, and that Spanish for medical practitioners, which is what is offered to her in her agency, is not very useful. She went on to say that what she misses most about being more fluent in Spanish, as she was when she lived abroad, is feeling at ease with the language. She reflected that while her grammar might improve with a class, a formal class would be unlikely to help her regain the comfort she once had with the language. She suggested that a conversation class might be most useful in this regard.

Some participants indicated that formal training on Latino/a cultures would be of use. Participant Thirteen said,

It would be great to get, sort of, cultural sensitivity, or cultural, um, history of the variety of countries of the folks who are- who I’ve worked with. Because I don’t know much about Uruguay, and I don’t know a whole lot about Peru, but boy, I’ve seen a lot of Peruvians, um, over the years...

Participant Three also indicated that he would like to learn more about Latin America. He explained that even though he has spent the majority of his adult life living in Latin America, he still feels that there is a lot more to learn. Participant Four agreed that formal training about Latino/a cultures can be useful, but only to a point. He explained, “I was taught in a way which I thought was bad, which was just, you know, learn little snippets about other cultures, and I didn’t like that.” This participant recalled asking a

presenter on cultural competence what the best way to learn to work in another culture is, and he was given the following response: “Let the people teach you when you work.” He went on to explain,

And it doesn't mean you don't educate yourself. Sure, you educate yourself, but keep it in the back of your mind... I guess what I'm saying is that I haven't really had a lot of training... which was really helpful, but I don't know that it's as important, the formal training, as is the informal training- let your clients teach you.

He explained that it is true not only of his cultural knowledge, but also of his language skills, that his best training is often on the job. He said, “If you're speaking the language six hours a day, it just keeps getting better. You keep learning new words, you keep getting more confident, and so to me, that's the best training you could have.”

Participant Eleven stated that she would like to be trained, specifically, on how to conduct clinical assessments in Spanish. She said,

I would really love to have more training in assessment, um, and communication of the assessment process and the treatment process in Spanish. So, you know, yes, I'm doing assessment in Spanish, and I'm doing it from English- so what we do in English, the same information I'm collecting in Spanish, but should there be more information or different information that we would collect, um, and I think there is. Sometimes it's different to talk about family structure, is different, but how to do that. Because I find so often, parents do not want to talk about their- their backgrounds. They do not. And especially, also, they don't- if they're not legal.

She added that she would like to have training,

Not just training about to be sensitive, because that always comes up, "You have to be sensitive." Well, ok, yeah. We know that, but tell me, what language do I use? In Spanish? How do I approach this subject being who I am? How do I communicate that I'm here to help you, not to put papers in your record that are then going to get you kicked out- which I'm not even sure.

This participant's wariness of “sensitivity” trainings reflects Participant Four's wariness of “cultural competency” trainings. Participant Ten had a similar complaint:

I mean, so many of the diversity trainings are so horrible, you know? And they try to cover all, sort of, marginalized groups, or different minority groups, or different ethnicities, and lump them all together into one giant thing, and think that we have a culturally aware organization, so, you know? It's just I think a lot of superficiality.

It seems that a good number of participants had previous negative experiences with trainings in culturally competency. They want trainings to be carefully conceived with specific content that is relevant to clinical work, and used as a starting point for the clinical encounter, rather than cursory attempts to convey a lot of information.

When participants addressed the issue of how they might access formal trainings, several participants indicated that their agencies of employment might have a role in this. Many agencies have funds set aside for their continuing education, and participants suggested that these funds might be applied towards Spanish language training. Participant Thirteen suggested that he might be able to advocate for educational funds being used towards private Spanish language tutoring. Participant Six wondered if there might be a way to build in Spanish language clinical training into her workday, or if bilingual providers might be provided additional educational leave time. She explained, “Unlike an English-speaking provider, who could just go and study what's most interesting clinically, I wouldn't have to choose between language and, sort of, issues, um, for my limited education leave.”

Several participants indicated that it would be helpful to have a native Spanish speaker observe their work and provide feedback. Participant Two said that this close observation would be very interesting and useful to her in helping her understand and evaluate some of the more clinical aspects of her work. Participant Five said, similarly,

What I feel like I almost need is like, an individual tutor who will like, follow me around for three days, and hear the way that I speak Spanish, and write down, ok, here's where you commonly get stuck, or make mistakes.

Participant Thirteen reported that individual tutoring that he has accessed has been very useful to him.

Participants suggested that peer support from other bilingual clinicians could be valuable. Participant Four suggested that peer support specifically from clinicians providing services in Spanish who do not speak Spanish natively could be very useful.

He said,

I've wanted for forever to start a group, actually, of non-native Spanish-speaking social workers that work with Spanish speakers, and I never did, but I've wanted to do it, because it's a little bit of a different experience, and I have a sense, like, I'll feel a little bit of a connection every now and then when I'll run into another non-native Spanish speaker or a White Spanish speaker, and we'll say, "Yeah, we're both kind of doing this a little bit outside of our language and our communities."

Participant Twelve stated that she would like for her agency to offer a case consultation seminar for bilingual clinicians, facilitated in Spanish. Participant Eight reflected that self-care and support exchanged between clinicians is extremely important given the stress levels particular to work with a disadvantaged population. She reflected,

Those of us who are doing this work, we understand what the other people are going through, we understand the weight that we all carry. But we are extremely aware about you know, checking in with each other, about, whatever. I'll check in tomorrow- you know, they're working today, I'll check in tomorrow with how they dealt with things, and what kind of weekend I had, or- it's a very supportive environment.

Peer support seems particularly crucial since several of the participants indicated that they did not know any other White clinicians who were providing services in Spanish, indicating a degree of isolation. Participant Three said, "I don't know any Caucasians

who do Latin American work. I've never really thought about it.” Participant Twelve provided the following example of the value of peer support:

There's this other therapist at this boy's school, and we were talking about mom, who, um, is a very interesting woman, and she- I mentioned the phone calls, and I said, sometimes it's really hard... and she's like, “Oh my G-d! I can never understand!” And we had this empathy about how hard it was to understand her on the phone. And I felt like better, you know. Because I'm sitting there, like, wait! People in every language talk fast. It's not just that I don't understand it (*laughing*).

Participant Seven indicated that more discussion about Spanish language work in general, and about cross-linguistic Spanish language work in particular, would be very useful to her. She reflected,

I mean, now that I'm talking to you, I'm like, “Gosh, you know, it's kind of invisible, you know?” The Spanish speaking piece, and also the cross-cultural White/Latino piece are not- have not been discussed at my- at my work.

She went on to add that most discussion at her agency about cross-cultural work is in the context of work between White clinicians and African American clients, which does not address many of the specific issues that she encounters when she provides services in Spanish with Latino/as. This participant suggested that speaking Spanish with bilingual friends over dinner or during other casual get-togethers would be useful to her.

Participant Nine agreed that she feels she simply needs to find more opportunities to speak Spanish, as does Participant Twelve, who feels she could benefit from as much exposure to Spanish as possible. Participant One said,

I think personally, if I were more active in speaking the language, um, I'd probably feel a lot better in the service I was providing, but because I've become more and more distant from speaking the language regularly, um, I feel more compromised.

Participant Twelve suggested that technology may play a role in the training of Spanish-speaking clinicians. She stated that she would like to have a computer-based learning program that included cumulative lessons and regular updates on new language trends. She would also like to have access to video recordings of therapy sessions conducted in Spanish. Several participants indicated that reading or watching television in Spanish has helped them improve their skills. Participant Two sings in a Spanish language chorus, which exposes her to a more poetic side of the Spanish language that she really enjoys. She said, of this experience, "It keeps me learning in a way that's not really like clinical in a way that I think is very relevant."

Personal relationships with Spanish speakers are a major source of learning for many participants. Participant Eleven noted that her friendship relationships with native Spanish speakers have provided a rich source of language learning, among other benefits of these friendships. Participant Nine said, "I have a housekeeper who speaks Spanish (*laughing*), and that's probably the most regular opportunity now to speak Spanish." Participant Two noted that a personal therapy relationship with a Native American therapist was an important source of learning for her on issues of White Privilege. She reported,

I was in therapy a lot myself in my training, with a therapist who wasn't Latina, but identifies as Native American, and so that was another perspective, too. You know? Because she'd be like, "Well, you're White, so you wouldn't get this, or that, or you know, be insulted all the time." And I'd be like, "Shut up!" (*laughing*). It was like, really weird... It was definitely an education in White Privilege, and my perspective. I mean, being in these agencies and in these relationships as a White person, and not in the power position, and experiencing that, and being kind of told, you know, "You don't get it."

She indicated that this relationship gave her a lot of insight into how her White cultural background informs her clinical perspective, which she then used to inform her Spanish language work. She reflected,

[I learned about] the kind of individually oriented perspective I brought to my work and my life, having grown up in a really individualistic kind of family. Whatever you do is fine, you know, just don't ask for money, and be independent, and we'll see you three times a year at the holidays, and that's my family, you know. Whereas, these families, they're always together, and you'd better pay for his college... you know, it's like a very different set of expectations about what family means, what friendship means, what you know, interpersonal kinds of relationships, responsibilities.

Several participants are or have been in intimate relationships with Spanish speakers, both native and non-native, and choose to use their Spanish skills regularly in the context of these relationships. Participant Thirteen reflected that he and his wife speak Spanish at home, in part so that their son can develop fluency in the language. Traveling to Latin America and interacting with his in-laws is also a source of language and cultural learning. Participant Twelve shared that she and her husband, both non-native Spanish speakers, practice their language skills with each other in the home. Participant One, who was formerly in a relationship with a Spanish speaker, reflected that she spoke Spanish outside of work much more frequently when she was in this relationship.

Many participants indicated that traveling, studying, and/or living abroad extensively is the best way to develop real fluency in Spanish. Participant Nine explained,

I think that my Spanish just got good when I lived in a place that was a Spanish speaking environment, and it has gotten better when I have done my little traveling. You know, so total immersion- there's nothing like it

Participant Thirteen said, “I think travel, foreign travel, is one of the best trainings, and I would love to have the opportunity to visit more different provinces in Mexico, and more of the other countries where people come from in Latin America.” Participant Nine suggested that, because of the value of foreign travel for language learning, her agency would better support bilingual services providers by providing subsidizing an immersion experience rather than by providing a language class. Participant Five realized, when she was studying and living in Mexico, that it was truly the interactions with native Spanish speakers that were the most important source of her learning. She reflected,

I was staying with some people in Mexico who kept saying, "Why are you going to school? You're learning more by talking to us" (*laughing*), which was probably true. So I feel like if I am going to do another, um, trip to specifically to work on my Spanish, it would have to just be spending time working on, you know, communicating and not necessarily going to another Spanish language program.

Participant Two recommended that White clinicians who are serious about using Spanish clinically should spend an extended time period abroad. She said that she encourages all of her supervisees to do this, and thinks that just after graduating from their clinical training programs is an ideal time to spend at least six months abroad. Participant Eight agreed that it is often easier for clinicians to spend time living abroad earlier in their careers, which she would also recommend. However, for practitioners like her, who are more seasoned, it becomes more difficult to consider taking this step.

Besides offering some of the opportunities for training and travel listed abroad, some structural supports were suggested that could help participants improve their Spanish language service provision. Participant Six suggested that one form of support

that her agency provides might be to provide additional time for Spanish language clinical sessions. She reflected,

Might it help to have more time for that session? ...I don't know. Have an hour and a half as opposed to an hour, you know, might help. Might help a lot, actually, thinking about it. I mean, I think everybody here would like to have more time for their sessions, especially, and, in fact, I know for a fact that even the [native] Spanish-speaking providers would prefer longer intakes because there are cultural issues that sort of imply the benefits of more time. A person may come in without their forms completed, or just, for cultural reasons, it makes sense to go a little slower.

She also indicated that her agency could better support Spanish language work by making more resources in the department available to Spanish language speakers, as they are to English language speakers. She said,

More resources in the department for Spanish speaking patients, other than individual therapy, like we have for English speakers, would help a lot, because then it would be like it is for the English speakers. We'd be one part of a plan that involves a variety of resources. As opposed to, sort of, a whole.

Some participants also indicated that their clinical training programs could have more of a role in training them, specifically, to provide services in Spanish. Participant Seven reflected that she would have liked to have more education specific to providing Spanish language services in her clinical training program. She reflected, of Spanish language clinical education,

I think it's a really important thing that we didn't really talk very much about, I feel like we didn't, because, I think- maybe the fear is that you'll make other clinicians feel bad for not speaking the language (*laughing*)... I feel like having an option to take a language course, you know, like, something that was preferably taught in the language, I feel like would be really helpful, and conducted in the language, and then also, you know, really focusing on those pieces, and it would be nice to have a little bit of flexibility around things that were coming up for people, or fears- just more support. Because there's just not a lot.

Participant Ten explained that she might feel more supported if clinicians who are passionate about providing services cross-culturally and cross-linguistically were more valued in general. She said,

I think that social workers would be better served to support people who want to do that kind of work, because they feel passionate about it, you know, in a different population, because I think that having that passion compensates in a lot of ways for other deficiencies.

She went on to explain,

I think getting away from lumping the, you know, you're a White clinician, you're a bicultural clinician, you're this, you're that, and kind of taking each clinician on an individual basis to sort of assess for, um, efficacy or ability or whatever it is, I think would be a better route to go if that's at all possible.

With so many ideas for how they might be better supported as non-native Spanish speaking clinicians, one might presume that participants felt hopeful about some of these supports becoming more available. However, while this was true for some participants, others felt that the training that they envision as being most useful is more of a fantasy than something they might expect to achieve. Participant Three indicated that the structure of his job and the demands of his large caseload prohibit him from expanding on his skills in the ways that he might like to. He explained,

My organization is always supplying trainings... but I simply do not have time. They always encourage me, "You've got to do more to do more trainings." I do want to learn more, I just simply do not have the time. I only go to trainings that are mandatory trainings. So those I go to, but otherwise, I simply cannot go to another training.

This participant suggested that a decrease in his caseload or work responsibilities might be the most useful support for him. Participant Six also indicated that she feels it is difficult to incorporate specific Spanish language training into her very busy schedule.

She said,

And as much as it would be fun to spend some time beefing up my Spanish, it would also be work, and I just don't necessarily feel like doing it off hours. And at certain points in time I don't even feel like doing it with my [educational] leave, because I want to use my [educational] leave to learn something new, um, that helps me more with the majority of my practice, as opposed to the minority of my practice.

Participant One said, “Professionally speaking, um, it's probably a pipe dream, but anyone who is providing services outside of their language, I think, should be in regular consultation in that language (*laughing*).” She adds that this consultation should be with someone who is either a native speaker of the target language or is very fluent in the language. When asked if some of her ideas about training truly would be a “pipe dream”, Participant One replied,

I personally couldn't imagine what we're tasked to do right now, in our setting, with our limited resources, how we could possibly financially support ways to fit that in, without really compromising care. So, yeah, it does feel like a pipe dream. Sadly. Maybe in other settings it wouldn't be, but in community-based settings, it is, right now.

She went on to say that she would also love for agencies to sponsor their employees for mental health language schooling programs. She said,

It would be great if those were made available to clinicians who would like to use the language more, and that they would be sponsored, and would get paid to be there, their education would be paid for, and their time off would be supported, to do that. Uh, that's not a high priority, unfortunately, in these times. Because I would love to do something like that.

Extended international travel, living, and learning was a suggestion for learning that was highly valued by all participants, but that felt least accessible. Participant Thirteen reported, of himself and his bilingual colleagues, “We've always joked about advocating, and again, to get [supervisory staff] to send us to language programs in Latin America (*laughing*), you know, dream on for that one.” Participant Eight said that for a

good opportunity for international learning, “It might be, you know, with *organization name deleted*, to go to Costa Rica for 2 weeks, but I can’t. Get real.” It seems that, because to this point, most clinical training programs and agencies that employ clinicians do not support clinicians in learning abroad, the challenge of making these trips happen falls exclusively on the clinician, and for many, seems unlikely. It also sets up a situation where clinicians must have economic privilege and limited caretaking obligations in order to access the ideal training. It seems that some participants are in a place of frustrated acceptance of the limits of the support and training they expect to receive in their work as Spanish language providers.

The question of how to increase support for White clinicians who want to provide services in Spanish may imply an underlying goal of increasing the numbers of White clinicians who are qualified to provide services in Spanish. Participant Seven pondered the consequences of increased support for language learning. She reflected, “I mean, you have to wonder, if there was more support, and more practical applications, and more ability to practice, would more clinicians take that step to learn Spanish? Or another language?” A few providers questioned whether prioritizing the recruitment and training of Latino/a native Spanish speakers in mental health care might be a preferable goal. Participant Nine reflected, in response to the question about how she might better be supported or trained as a Spanish-speaking provider,

I guess, my first thought is I think the ideal is having a native Spanish-speaking provider, so that's my first thought, and that's part of my worldview, of wanting to raise the level of education and, um, you know, lives, of lots of the people that I've seen, and thinking, "Oh, here's this really bright kid. They should go off to college. They've already got bilingual skills", and, you know, I wish they would go and become doctors, or therapists, so that's my first thought. Um, I don't really

think Caucasians need as much help in improving their lot. And of course, that's a generalization, and plenty of Caucasians are not living the best lives either.

Participant Eight said that she already sees a trend towards more Latino/a providers becoming qualified to provide clinical services, and non native-speaking Spanish language providers becoming less marketable. She reflected,

Because with the change in the population coming out of university, I don't think that people like myself who speak Spanish as a second language are gonna have much space. I think it's going to be, you know, the Spanish speakers, the truly bilingual people, who are going to be doing this kind of work... I think there is going to be a significant shift- there are going to be psychologists, licensed clinical social workers, a lot more of them who are very good with the language. So- and that's what should be happening.

As she reflected on this further, she noted that while numbers of native Spanish-speaking professionals are increasing, the general Spanish-speaking population in the United States is also increasing rapidly, so there may continue to be a need for as many Spanish-speaking providers as possible, especially in certain regions.

In sum, the participants suggested a wide range of ways in which they could improve the quality of the services that they provide in Spanish, and that their clinical training programs and agencies of employment could better support them in making these improvements. Spending time living in a Spanish-speaking country was the most highly regarded form of preparation, and one that was used by all participants. In addition to this foundational preparation, many other forms of support and training were experienced as or thought of as useful. Most participants responded first with ways in which they, personally, could increase their Spanish language fluency and familiarity with Latino culture. Importantly, many participants were already engaging in ongoing efforts to maintain and improve their Spanish language skills, often on their own time and at their

own expense. Only when the participants were specifically prompted by the researcher to consider how their clinical training programs and/or agencies of employment could contribute to their continued learning did most participants offer suggestions in this regard, and, when they did, participants were mixed in their confidence that these suggestions might be realized. This indicates that many participants have become accustomed to taking full responsibility for their training to provide clinical services in Spanish, and discouraged from seeking support from other sources. While of course, it is helpful for clinicians to be motivated in their own learning, it is also helpful to think about what supports might be offered to them, and what it means that many of clinical training programs and agencies of employment make few efforts to train and support Spanish-speaking providers. After all, in many other areas of clinical training, clinicians can expect to receive more formal education and more agency support, or at least, can expect to be able to access good training opportunities privately. Improved support from clinical training programs and agencies of employment would benefit not only Spanish-speaking providers, but also, and most importantly, Spanish-speaking clients, as the most effective supports would increase the quality of Spanish language services that are available.

Summary of Findings

In sum, the findings of this study indicate that White social workers and psychologists usually have both personal and professional motivations for providing services in Spanish. Their development of Spanish language skills, development of clinical skills, and choice to provide clinical services in Spanish, occurs over a long period of time and is a process of continuous choosing, decision-making, and learning.

For White clinicians, knowledge of Spanish invites opportunity and challenge. While on the one hand, they are able to connect with monolingual Spanish speakers, engage in rewarding and needed work, and may experience an advantage in their careers, on the other, they face unique linguistic and cultural challenges. The challenges that providers face are varied, and while some are felt most intensely early in providers' careers, others continue to be present even for clinicians who are very experienced in this type of work. Clinicians notice that their Spanish-speaking clients tend to respond to them warmly, and are accommodating and gracious around any limitations in the clinicians' Spanish language skills. Still, clinicians observe and/or imagine that Spanish-speaking clients relate to Latino/a providers with more familiarity and ease, and the clinicians do not generally see their Whiteness as an advantage, except under particular conditions. Rarely do participants refer their Spanish-speaking clients to native Spanish speakers, due both to access and to clinical preference, although many wish that they could under certain conditions. Spanish speakers tend to be appreciated and valued by non-Latino/a colleagues and supervisors, and encouraged and mentored by Latino/a colleagues and supervisors, with rare exceptions. When it came to considering the quality of the Spanish language services that they are able to provide, most providers indicated that their skills in providing services in Spanish were some degree lower than their skills in providing services in English. However, clinicians who were more fluent in Spanish were more likely to indicate that they still felt able to provide high-quality services, while less fluent clinicians were more concerned about whether they were truly able to provide adequate services. Finally, participants generally felt that much of their learning to provide Spanish language clinical services has come through their own initiative, and suggested

many ways in which they might continue to improve their skills, and ways in which their clinical training programs and/or agencies of employment could be more supportive to them in their learning.

CHAPTER V

DISCUSSION AND CONCLUSIONS

The purpose of this study was to explore what motivates White social workers and psychologists to provide services in Spanish to Latino/a clients, and what their experiences are in providing these services, including perceived benefits and challenges of this work. Recommendations were solicited as to training and support that might help this cohort of professionals meet the challenges of this kind of cross-cultural, cross-linguistic work. The most significant findings of the study, which are presented for discussion in this section, are as follows. Participants came to Spanish language clinical work with personal, professional, and political motivations. They tended to feel that their identities as White, Spanish-speaking clinicians, invited both opportunity and challenge. Participants tended to find this cross-linguistic work challenging in various ways, throughout their careers. However, while clinicians who were newer to the work tended to express more concern about linguistic challenges, more seasoned clinicians tended to express more concern about cultural challenges. Participants tended to experience responses by clients, colleagues, and supervisors to them as Spanish-speaking providers as appreciative and supportive. However, there were more exceptions to this trend among the participants' colleagues, and specifically, among their Latino/a colleagues. Participants ranked the quality of the services they were able to provide in Spanish as generally lower than the quality of the services they were able to provide in English;

however, more experienced participants felt more able to provide high-quality services regardless. Finally, participants tended to have received much of their training and ongoing education specific to providing clinical services in Spanish independently of any formal clinical or employer training, and felt that they could benefit from more systemic support of various forms for their training. In this section, the researcher will consider these findings and their implications in the context of previous research on the topic.

Discussion of Findings

While in the literature, there is some controversy around rate of need for mental health services in Latino/a populations (Alegría et al., 2008; US Department of Health and Human Services, 1999), from the perspective of study participants working in the field, it is evident that many Latino/as are presenting for mental health treatment, and that Spanish language clinical services are highly in demand. Participants found that their Spanish language skills were highly desired by agencies of employment, and once participants were employed, they were encouraged to use these skills by supervisors and colleagues, sometimes even when the participants themselves had doubts about their qualification to do so. Several participants did note, as was indicated in a previous study (Altarriba & Santiago-Rivera, 1994), that Latino/as seem to present with fewer diagnosable psychiatric disorders and more symptoms induced by stress and/or trauma than their White peers. However, others noticed no trends of this sort. Previous literature indicates that there are not currently enough native Spanish-speaking clinical providers to meet the needs of Spanish-speaking patients (U.S. Department of Education, 2006), and many participants indicated that this discrepancy is evident in their practice, and a part of their motivation to provide Spanish language services themselves. Still, participants gave

a more nuanced picture of the availability of Spanish-speaking clinicians in the field. Several participants noted that a particular agency's hiring of native Spanish-speaking clinicians has as much to do with particular recruitment policies, like encouraging bilingual, bicultural applicants to apply, or certain forms of networking, as it does with the general availability of these candidates in the field. In addition, several participants observed that there are increasing numbers of Latino/as receiving college educations and clinical degrees, and anticipate an increasing availability of these practitioners in the field. Still, at present, most participants indicated that there seem to be considerably fewer Latino/a Spanish-speaking clinicians available than would be necessary to meet the needs of clients requiring Spanish language services.

Since previous literature rarely mentions the motivations or identity constructions of White, Spanish-speaking clinicians, the finding that most participants have both personal and professional motivations for engaging in Spanish language clinical work is a new one. While it might be assumed that their Spanish language skills would be an advantage to them professionally, and potentially in the interest of clients in need of Spanish language treatment, it was remarkable to what extent, over how much time, and in how many ways many participants had incorporated Spanish language and Latino/a culture into their lives. Many participants felt a connection with Latino/a communities that was more felt than entirely explainable, and that was overwhelmingly positive. On the other hand, when thinking about their own identity constructions, participants' feelings about themselves as White Spanish speakers were more mixed. The pull and the joy of learning and speaking Spanish, and interacting with Latino/a communities, was still there, but it was, in some ways, tempered by the challenge of using these skills in

situations that involved the great responsibility of caring for a client's mental health needs. In this way, many participants experienced a split; they had overwhelmingly positive feelings about themselves as Spanish-speaking people, but more conflicting feelings about themselves as Spanish-speaking clinicians. These sentiments invoke the findings of a previous study that described a split in the identities of Latino/a, Spanish-speaking clinicians (Castaño, Biever, Gonzalez, & Anderson, 2007). It seems that both Latino/a and White Spanish speakers tend to feel more positively about speaking Spanish outside of work, and more conflicted about using Spanish in the workplace, since this is not the language of their clinical training. This finding suggests that both native and non-native Spanish speakers would benefit from specific training around integrating Spanish language skills that they have acquired largely outside of the clinical setting into their professional identities and their clinical work.

Participants' comments about potential benefits of their White identities in their work with Spanish-speaking clients add some depth and contrast to the ways in which this topic has previously been broached in the research. All participants felt that on the whole, their Whiteness was not advantageous in their treatment of Spanish-speaking clients. This was the only question to which all participants responded with the same overarching response, indicating a strong trend. As important, though, is that almost all participants, even as they denied a general sense of advantage, were able to locate some instances in which, or some clients for whom, their Whiteness did seem to be an advantage. When they did talk about Whiteness as an occasional advantage, several participants echoed an idea expressed in previous literature, that a client may experience increased power in a relationship where the clinician encourages the client to be the

expert on his or her language and culture (Kitron, 1992). Participants emphasized that this sharing of power may be especially important in a context where Latino/as may be approaching a therapy relationship from a position where they might assume that they have less relational power. However, participants were more cautious and conditional in their responses than was the researcher in a previous study (Kitron, 1992). They reported that these and other benefits were mostly incidental, and that in general, they felt that their Whiteness was rarely to their advantage in their treatment of a Latino/a client. Also, several participants pointed out that what clients may perceive as advantages in receiving services from a White clinician may have to do with the client's internalized racism, and not with any inherent advantage that might be offered within the cross-cultural, cross-linguistic dyad. Thus, the results of this study indicate that while there might initially be certain perceived advantages of a clinicians' Whiteness, context should be considered to understand how this advantage is understood, and how it might be used or questioned in the therapeutic relationship.

The bulk of previous research suggests, though usually not directly, that it is challenging for White, Spanish speakers to provide services in Spanish. Participants' responses were compatible with these findings. Participants confirmed the concerns of previous researchers (Acevedo, Reyes, Annett, & López, 2003), who objected to the cursory ways in which competency to provide therapy in Spanish is currently being assessed. Several participants indicated that they were hired as Spanish-speaking clinicians with no one having ever heard them speak Spanish, let alone having tested their skills formally. This indicates that agencies of employment may be too quick to assume Spanish language clinical competency, perhaps due to their underestimating the challenge

of cross-linguistic service provision. These findings confirm a need for more rigorous evaluation of language skills for Spanish-speaking clinicians.

In considering various challenges of cross-linguistic work, an important finding of this study that is not reflected in previous literature is that participants with less fluency in Spanish tended to mention more linguistically-based challenges, while participants with more fluency in Spanish tended to mention more culturally-based challenges. In a way, this is intuitive, as less fluent Spanish speakers would necessarily struggle with language in ways that more fluent speakers would not. However, the interesting finding here is that for less fluent Spanish speakers, their struggle with the language sometimes took precedence over culturally-based challenges that were more salient for more advanced speakers. Some of the least fluent Spanish speakers found that they needed to concentrate so much on comprehending their clients and putting their own thoughts into words that they found themselves focused mostly on content, sometimes even avoiding questions that might lead to more complex or affective content. The result of this is that while difference is very salient in a clinical relationship between a client who is fluent in Spanish and a clinician who is struggling to understand that client, the clinician may not have the language to manage a conversation about what this difference means. If a conversation occurs at all, it may stay only at the level of linguistic difference, when linguistic differences are truly an entry into a whole range of cultural differences. Therefore, the findings of this study indicate that less linguistic difference between the client and clinician, in terms of proficiency in Spanish, seems to enable clinicians to better address cultural difference in a meaningful way.

The challenge of managing linguistic countertransference surfaced for some participants, but may be an area in which participants might consider further exploration, especially in the context of a previous study that encourages clinicians who provide services in their second language to explore this component of their work (Clauss, 1998). For all participants, the process of becoming proficient in Spanish occurred over several to many years, and generally involved an intersection of the academic, the professional, and the personal. It took many participants on a path through various countries, and through various relationships with teachers, mentors, friends, partners, and clients. Some participants had an understanding of what drew them to become proficient in Spanish, and what feelings they associate with Spanish language and Latino/a cultures, while others were less aware of these elements, and how they might affect their countertransference in working with Latino/a clients. This might be an area in which participants could benefit from increased opportunity to reflect on the personal aspects of their work, whether in supervision or peer consultation. Clauss (1998) explores disclosure of Spanish language fluency as a critical therapeutic moment in which transference and countertransference content often emerges. The findings of this study indicate that disclosure of and conversations about limits in Spanish language fluency also constitute critical therapeutic moments which are also often rich with relational content. Many participants make a habit of making this disclosure early in the treatment, and consider this disclosure important, but they uniformly report that the disclosure yields little substantive discussion in the moment. Many of these clinicians see this disclosure as an invitation to bring up difficulties around linguistic difference later in the treatment. Still, it would be interesting for further research to continue to explore the

meaning of these disclosures, and if there might be a way of talking about linguistic difference that does invite more meaningful conversation.

A challenge mentioned by several participants was that of working within a system that was not wholly supportive of Spanish language work. Although it seemed to be a given for most participants that they would speak Spanish with clients who are dominant in Spanish, as previous research suggests constitutes the best practice (Gutfreund, 1990; Marian & Neisser, 2000), the impact of English-only bias was felt by several participants. Several participants found that the range and quality of Spanish language services offered in their departments was lacking in comparison to the English language services that were offered. Also, several participants found that, while they were appreciated for their provision of Spanish language services in certain ways, they were not always given the financial and structural support that might indicate a deeper level of appreciation. It seems that in some agencies, a bias towards English may have steered some administrators towards giving less priority and structural support to Spanish language services, and not being as concerned about outcomes in terms of quality of Spanish language services as they might have been. On the other hand, for participants who worked in agencies or departments that served primarily Latino/a clients, services were sometimes available to Spanish speakers that were not available to English speakers, and some participants felt more knowledgeable about Spanish language collateral resources. The results of this survey, then, suggest that agencies may tend to specialize in either English language or Spanish language services, and few are successful at integrating services in both languages that are of equal range and quality.

Participants indicated that, on the whole, clients, supervisors, and colleagues were appreciative of them as Spanish language providers, and provided positive feedback to them around their skills in a variety of forms. The participants in this study have made tremendous personal and professional commitments to serving a population in need. It is the opinion of the researcher that they should receive appreciation for this contribution. However, one might still inquire whether there are other factors, besides their praiseworthy contributions, that might lead the participants to receive scant negative feedback around their skills, especially when many of the participants acknowledge themselves that their skills are sometimes not what they would like them to be. Several participants mentioned that they thought that many of their clients were probably too polite to request a clinician transfer, object to the clinician's level of Spanish language proficiency, or to interrupt the clinician when they did not understand. A Latino/a cultural norm of accommodation and graciousness may be getting in the way of clients being honest with their clinicians about their concerns around negotiating the language difference. Internalized racism may also lead clients to believe that they are not entitled to receive the quality of services that they might prefer, and should be grateful for what services are offered.

When participants did mention cases in which they were received negatively as White Spanish-speaking providers, this feedback came almost exclusively from Latino/a colleagues. While these instances of receiving more critical feedback were rare, and participants generally felt Latino/a colleagues to be sources of support, friendship, and mentoring, the trend of more mixed experiences is worth noting, as it applies to at least five of the thirteen participants. These participants recalled instances of Latino/a

colleagues criticizing the hiring or accents of White Spanish speakers, reacting critically when participants requested certain forms of support, or responding with a general sense of coldness or exclusion towards White Spanish speakers. Participants tended to attribute these experiences to the particular orientations or experiences of particular clinicians with whom they were reacting. However, as a trend, it seems that these experiences may emerge out of group relationships between Latino/a Spanish speakers and White Spanish speakers as a whole. When White clinicians become fluent in Spanish, they add language advantage to augment their already existing White Privilege. Having both racial and language advantage can yield rewards that are not available to Latino/a clinicians, for whom language advantage is one of few sources of group power. Therefore, Latino/a clinicians may feel conflicted about White clinicians providing services in Spanish. They may feel grateful that these clinicians are sharing the responsibility of serving the Spanish-speaking population, concerned about the linguistic or cultural competency of these clinicians, and/or protective of Spanish language work as a niche and source of power for Latino/a clinicians. It seems that a peer-to-peer power structure may have enabled Latino/a colleagues to name more of the complex feelings that they held about their White Spanish-speaking peers, while responses from supervisors and clients were more contained and positive due to a differential power structure. The findings here open up the possibility that White Spanish-speaking clinicians impact Latino/a Spanish-speaking clinicians and the nature of Spanish language mental health services in general in both positive and problematic ways.

When participants were asked about differences in their clients' responses to them versus how they observe or imagine that their clients respond to their Latino/a colleagues,

participant responses confirmed previous research that indicates that White providers tend to have different relational styles than Latino/a providers (Lu, Organista, Manzo, Wong, & Phung, 2001; Zuniga, 1991). The participants, like these researchers, reported that their Latino/a colleagues tend to be more exploratory in their work, and provide more culturally relevant interpretations, while the participants are more distant, formal, and directive. Participants observed that their Latino/a colleagues tended to be more at ease with their Latino/a clients, joking with them more, being more familiar or casual, and recommending traditional remedies in addition to more conventional clinical advice. Interestingly, many participants attributed this difference not to their own cultural style or preference, but to a choice to provide services in a more formal way, because they believed that their Latino/a clients preferred or expected a more directive style, where the clinician assumes an authoritative role and prescribes a certain course of treatment. Also, even as the participants observed aspects of clinical style in their Latino/a colleagues that seemed to be effective for clinical treatment, they were cautious about incorporating these aspects into their own work. Several participants were concerned that they could not do this in a way that felt authentic to them and useful to their clients, and that it felt more appropriate, given the cultural distance, to be more formal and professional. No participants mentioned using many *modismos* or colloquialisms in their own speech, as recommended by one researcher (Zuniga, 1991). Thus, the findings of this study confirm that White clinicians do tend to provide less culturally relevant care. However, in this study, participants usually chose to provide services differently than their Latino/a colleagues out of respect for their clients and the real cultural distance between them and their clients, not because they were automatically operating in a way informed by their

own culture. Thus, there may actually be good reasons why a White clinician's care for a Spanish-speaking client may look less culturally relevant than a Latino/a clinician's care for the same client. At the same time, it may also be that participants are too quick to assume that they could not or should not model their clinical styles after their Latino/a colleagues. While Latino/as may present for treatment expecting a certain style of more authority and distance from a clinician, much of the growth and work may come when this distance starts to decrease, as is evident in the modeling of Latino/a clinicians.

Many participants indicated that the quality of services that they provide in Spanish is not as high as the quality of the services that they provide in English. This indicates that at least in the population of these clinicians' caseloads, clients are receiving services that are unequal in quality based on their linguistic background, and consequently, that there are racial differences in who gets services of what quality. This is a concerning finding. What this finding does not tell us, exactly, is whether the quality of the services that the participants are providing can still be understood to be "good" or "high". Some providers, generally the more fluent and experienced providers, indicated that they did believe that this was the case. Some of the most fluent providers actually indicated that they did not feel that there were quality differences in the services that they provided in English versus in Spanish. Others, especially those who were less fluent or newer to the work, were quite concerned about quality differences in their service provision in English versus Spanish, and did not always feel able to provide high-quality services. This is a case in which the concerns of those participants who are less fluent in Spanish are especially important, perhaps even more so than the reassurances of more fluent providers. When clinicians provide services in a language in which they are less

fluent, quality of care will usually suffer, in some way. This affects clients on an individual level, and also means that Spanish-speaking clients, as a group, will not receive the same quality of care as English-speaking clients. Particularly in the context of previous research that indicates that an ethnic match results in better treatment outcomes and fewer premature dropouts for Latino/a clients (Sue, Fujino, Hu, Takeuchi, & Zane, 1991), the concerns of participants around the impact of both cultural and linguistic difference on quality of care are significant.

The basic question that this discourse leads to is, should clinicians who do not speak Spanish natively provide services in Spanish? How fluent do these providers need to be in order to provide these services ethically? In which settings or situations do limits in these clinicians' Spanish language fluency and cultural competency have the least impact, and in which settings or situations do they have the most impact? Finally, what support and training can best set up White Spanish speakers to provide services in an ethical manner, in the broadest range of settings and situations?

Looking forward

In order to address the question of whether White, Spanish-speaking clinicians should be providing services in Spanish, we need to look realistically at what will happen if they do not provide these services. As is represented in the previous literature, and as is known by the participants from their experiences of working in the field, there are simply not enough native Spanish-speaking clinicians who are currently qualified to provide clinical services in Spanish to meet the needs of the clients in need of services in Spanish. However, this finding can easily be misinterpreted to justify the provision of low-quality Spanish language services. A phrase that is heard in many agencies of

employment around the topic of non-native Spanish speakers providing services in Spanish is, “It’s better to provide some treatment than no treatment at all.” While this is partially true it also sets up a false binary. From this statement, we might presume that Spanish-speaking people in need of clinical mental health services should expect to receive either poor treatment or no treatment. This is not just. This statement also implies a certain amount of pessimism and contentment with the status quo. This is not useful. Participants in this study mentioned a wide range of interventions, at many different cost and commitment levels, that would improve the quality of the Spanish language skills that they are able to provide. The possibilities for improving Spanish language mental health services are vast, and can happen incrementally, in many different locations.

First, it is the opinion of several participants in this study, and of this researcher, that a primary goal of clinical training programs, individual agencies of employment, and the social work and psychology professions as a whole, should be to recruit, train, and support native Spanish-speaking Latino/as in pursuing careers in mental health. Clinicians who speak Spanish as their native language are equipped to provide services in Spanish in ways that clinicians who speak Spanish non-natively need to work at for years. It should be noted that several participants in this study questioned what they perceived of as a preference for bilingual, bicultural providers, and felt that this preference involved assumptions about all Latino/as being fully bilingual and bicultural, and about all non-Latino/a clinicians being somehow inferior. While these questions are received by the researcher with interest, it remains the opinion of the researcher that most Spanish-speaking Latino/as do bring a richness of linguistic knowledge and cultural

understanding to work with Spanish-speaking Latino/as that is unparalleled by other groups. At the same time, with the recruitment and training of Spanish-speaking Latino/a clinicians as a primary goal, this researcher, and many of this study's participants, envision Spanish language services being provided by White Spanish speakers not as a second-rate option for a population that would otherwise not be served, but as part of a larger solution that, challenging and complex as it may be, is a real, good option for providing high-quality services to a population in great need.

In addition, this researcher would like to suggest that the goals of recruiting, training, and supporting more Spanish-speaking Latino/a clinicians in the field and recruiting, training, and supporting more Spanish-speaking Whites people in the field, are actually complementary to each other. Some participants indicated that there is a false idea in the field that Latino/a clinicians are necessarily fluent in Spanish and prepared to use their Spanish clinically, and even, that they are necessarily adequately familiar with and competent in working with Latino/a populations. Both White and Latino/a Spanish-speaking clinicians will benefit from specific Spanish language clinical education, which will teach them how to clinically apply Spanish that they have often learned primarily through lived experience. Both will benefit from increased support from agencies of employment for Spanish language work. This support should involve appreciation, but also, increased concrete supports and monetary incentives. Both will benefit from in-depth training about the range of Latino/a cultures, focused specifically on clinical interventions that are both culturally responsive and relationally sound. Latino/a Spanish speakers are critical resources for supervision and consultation for White Spanish-speaking providers. At the same time, White Spanish speakers are an important resource

for Latino/a Spanish speakers in sharing the responsibility of servicing the needs of Spanish-speaking clients. Should a time come in the future of the social work or psychology professions in which enough qualified native Spanish-speaking clinicians are present in the field to service the needs of the presenting clients, we might re-consider whether it makes sense for non-native Spanish speakers to continue to serve this population. Importantly, many participants indicated that they enjoyed working in Spanish, and would want to continue this work even if it weren't required of them. Still, an increase in Spanish-speaking providers in the field, or even in a particular agency, would reframe the question. The question might then be, if and when White Spanish speakers serve the clinical needs of Latino/a Spanish-speaking clients. Realistically, the question, now, though, is how White Spanish speakers can best serve the clinical needs of Latino/a Spanish-speaking clients, since their services are clearly in demand.

Participants' ideas for how they can better be supported or trained in providing clinical services in Spanish can be summarized as follows. Ideally, Spanish language itself is best learned through lived experience in Latin America or Spain. While formal Spanish language training can improve certain aspects of communication and can accelerate learning, some of the best training can come from speaking with native speakers in less structured settings. Unfortunately, the cost and commitment of this kind of training results in this option being less available to less economically privileged individuals, older individuals, and individuals with caretaking and other personal commitments. Functionally, this means that economically privileged, younger, single people with no parenting or elder care responsibilities are more likely to be able to access the ideal training than others. Given how economic privilege is stratified in the U.S., this

also means that White individuals may be more able to afford to spend time living or studying abroad than individuals from other racial groups, including Latino/a individuals. Thus, subsidies for training abroad would be an ideal way to making Spanish language fluency more accessible for the most diverse range of people. Short of that, though, participants did mention a large range of additional forms of training that would be useful to them, most commonly including Spanish language training, training about Latino/a cultures, and a variety of forms of agency support, include Spanish language supervision and consultation. While the participants regarded these forms of training and support as very useful, they were generally seen as supplemental to a base of Spanish language proficiency, not as a primary means to train clinicians to be fluent in Spanish. Therefore, in addition to promoting education and living experiences abroad, when possible, these responses also indicate a need for more investment in domestic opportunities for substantive Spanish language learning, in order to make development of Spanish language fluency more accessible to more people. No participants emerged from High School, or even from college or university, fluent enough to competently provide clinical services in Spanish without additional training.

While development of increased Spanish language fluency, on its own, was noted as an important goal for many participants, an important finding of this study is that a high level of Spanish language proficiency does not lend itself easily or automatically to proficiency in providing clinical services in Spanish. Participants in this study had very little training specific to providing clinical services in Spanish, and many mentioned that this could be helpful, whether through their clinical training programs or through their agencies of employment. Again, since many of the opportunities of which clinicians

were aware were costly and time-consuming, participants and others would benefit from these being offered in more affordable, accessible forms, including through the clinical training programs for which clinicians are already paying. Promising models for training Spanish speakers, native and non-native, to provide clinical services are emerging (Biever, Castaño, de las Fuentes, González, Servín-López, Sprowls, & Tripp, 2002; Cox, Falk, & Colon, 2006). Agencies of employment might also take a larger role in preparing their clinicians specifically for providing services in Spanish by funding and allowing time for Spanish-speaking clinicians to receive supervision and/or consultation in Spanish, among other supportive means.

The findings of this study indicate that, were opportunities for training and support to be offered in a way that was accessible to clinicians, the participants would be likely to take advantage of these opportunities. In contrast with a previous study (Amato, 2007), participants were motivated to pursue their own learning in cross-cultural, cross-linguistic work. They had thought critically both about their Spanish language skills and their cross-cultural competency, had pursued training on their own, especially in Spanish language, and expressed commitment to continuing with this educational process. Unlike Amato's finding that White clinicians who work with Latino/a clients did not find that cultural differences affected the therapeutic relationship in any way, participants in this study named a range of ways in which these differences impact the therapy, and a range of methods that they use to navigate these differences. In hypothesizing the reasons behind differences in the findings of these two studies, one might consider that this study represented a more expert sample of proficient and fluent Spanish speakers, while in the Amato study, only one third of the participants were highly proficient in Spanish, and one

third had no functional Spanish language skills. Therefore, it is possible that higher levels of fluency in Spanish correlate with increased cultural competency and a more thorough understanding of the challenges in cross-cultural work. In addition, participants in this study were located mainly in major California cities that are deeply and historically multicultural and have large Latino/a populations, while the previous study took place in less diverse Western Massachusetts. It may be that the demographic and political context of the area in which this study takes place yields a wider expectation and understanding of cultural competency.

In sum, the results of this study indicate that White, Spanish-speaking clinicians believe that the quality of care that they are able to provide to Spanish-speaking clients can significantly improve with increased training and support. The ideal training for creating a base of Spanish language fluency is informal, through lived experience abroad. However, many forms of support and training offered domestically could supplement a base of Spanish language proficiency in a meaningful way. Specifically, clinical training in providing Spanish language services, offered by psychology and social work training programs, and support through agencies of employment, such as Spanish language supervision and consultation, would be particularly useful. The findings indicate that many of the barriers to participants taking advantage of more opportunities for training or support have to do not with motivation, but with logistical factors like time and money. Were these opportunities to be made more affordable and accessible, most participants are highly motivated to improve their skills.

Recommendations for further research

The major area for further research indicated by these findings is an exploration of the other perspective of the dyad in question, or namely, of clients' experiences of receiving services in Spanish by a clinician who does not speak Spanish as his or native language. While participants reported that, in general, their clients responded warmly and graciously to them, they also wondered if they may be too polite to talk with them about some of their concerns. Importantly, participants more frequently reported receiving less warm or gracious feedback from Laitno/a colleagues than they did from clients. Presumably, participants had closer, more long-term relationships with colleagues that were more equal in terms of power, and they may have received more honest feedback. More complex responses, including negative responses, may be retrieved if clients were asked about their experiences in these dyads, lending to a fuller picture of dynamics with the clinical pair. It is this researcher's opinion that this work might best be done by a researcher who shared the cultural and linguistic background of the client group in question, to avoid association between the researcher and the participants' clinicians. In addition, the question of quality of service provision calls for quantitative study of differences in client retention and/or treatment outcome when the clinician is not a native speaker of the language of treatment. In addition to these major areas of research, much room remains for specific research into the types of clinical services provided in different settings, where non-native Spanish speakers are able to be the most effective and where they are least effective, and what strategies and styles might be used in each setting to provide the highest quality services.

Limitations

Because non-random sampling was used to obtain the participant sample interviewed in this study, several trends in the participant population are worth noting, which may skew the results of this survey towards being more applicable to the experiences of the particular groups that are represented here. It remains to be seen whether these trends are evident in the population of White Spanish-speaking clinicians in general, or are particular to the population interviewed here. Six of the thirteen participants identified as Jewish in ethnicity with one more participant identifying as of mixed ethnicity, including Jewish. No particular efforts were made by the researcher to solicit Jewish participants. It may be that economic and/or educational privilege associated with this population allowed for more opportunities for language learning. It may also be that individuals of Jewish identity feel a particular calling towards cross-linguistic work, given family and cultural histories of immigration, or perhaps, given early exposure to Hebrew as a second language. The source and impact of this trend, if it is a trend, would require further research, as it was not explored with participants here. Also, the participants were skewed towards doing more work with children, with eight participants working exclusively with children and families. Many participants who did work with children indicated that they did most of their work with children in English, while the children's' parents were often the monolingual Spanish speakers in the family system. This combination offered participants an opportunity to do the bulk of their work in English, the language with which they felt most comfortable, while using their Spanish skills in a productive and important way. It could be that this type of work especially suits clinicians who want to use Spanish professionally but are limited in their Spanish

language skills. However, given that parental involvement is very important to the effectiveness of treatment with most young people, as is an alliance between the parents and the clinician, further research might explore particular issues around family work.

Limits of the reliability of study include use of self-report as the only tool of evaluation, including for language proficiency. Several participants reported some difficulty with the chosen tool used to classify language proficiency, lending further doubt to the reliability of self-reported proficiency. The lack of reliability of self-reporting also may impact to participants' assessments of their clinical skills and the quality of their service provision. Some participants indicated that they were not always sure when their concerns about their skills were due to a lack of confidence, and when to a lack of skill. Self-report may have been particularly problematic as a tool in understanding responses to participants by clients, peers, and supervisors. The data may also be biased by geographic location. Since all participants reside and work in California, and most work in urban areas with large Latino/a populations, some results may reflect the particular cultural context in California, and may not be generalized to other locations, or areas in which the population of Latino/a clients and/or clinicians is not as large.

Final thoughts

The participants interviewed in this study came into Spanish language mental health services with strong personal, professional, and political motivations to serve a population in need, and, importantly, a population with which, for various reasons, they truly enjoy working. They have devoted a lot of their own time and, often, money to learning Spanish and improving their skills in providing clinical services in Spanish, and

have done so out of want and with a spirit of good will. Most participants feel deeply connected to this work, and want to continue to do it with increased competency. There are many good reasons for these clinicians, and other White Spanish speakers, to make the choice to provide services in Spanish to Latino/a clients. There is a large need; there is an ethical and political motivation to provide services to this population; there is encouragement from colleagues, supervisors, and clients; there may be career or monetary incentive; and there are the strengths and charms of Latino/a communities. Participants have good reason to feel proud of the work that they are doing. At the same time, findings of this study indicate that White clinicians also have good reason to be cautious and thoughtful about their work, humble about the quality of their service provision, even when they receive positive feedback, and open to the idea that in some cases, they may not be well-suited or even qualified to treat a particular case. It seems useful for clinicians to be aware of the limitations in their skills at every point in their career, even as increased fluency and skill yields more confidence, because the work of becoming truly competent in providing services across both cultural and linguistic difference is ongoing.

The findings of this study suggest that White Spanish speakers can contribute to providing high-quality care to Spanish-speaking Latino/as. They are by no means the solution to servicing all of the needs of all Latino/a Spanish-speaking clients, but a part of a viable plan to improve the quality and accessibility of Spanish language services that includes, and prioritizes, the recruitment and training of Latino/a Spanish speakers. While non-native Spanish speakers face particular challenges in developing fluency in Spanish and navigating cross-cultural dynamics, this work is likely to be challenging for

White Spanish speakers and for Latino/a Spanish speakers alike so long as the dominant language of clinical education is English. All Spanish-speaking clinicians will require a good deal of training and support in order to adequately meet the challenges of the work.

Predictably, the availability of training and support is informed by economic realities in the U.S. and of agencies providing mental healthcare services. Still, we must consider the need for supportive resources for the training of Spanish-speaking clinicians as a responsibility that must be met somewhere in the mental healthcare system. Maybe it can be met by clinical training programs, when they incorporate specific training in Spanish language work into their curricula. Maybe it can be met by agencies of employment, when they provide increased support, including concrete support, to their Spanish-speaking employees. Maybe it can be met by the providers themselves, when they use their own resources to educate themselves, and make a personal commitment to integrate Spanish into their lives. Most likely, improved training and support will require collaborated efforts of all three. But, when the responsibility for providing adequate training for clinicians providing services in Spanish goes unmet by clinical training programs, by agencies of employment, and by individual clinicians, the client not only receives substandard care, but also ends up shouldering the responsibility for educating the clinician. The clinician learns as he or she works, and the client is literally responsible for helping the clinician improve his or her fluency in Spanish and improve his or her knowledge of Latino/a cultures. While some degree of learning from the client happens in almost every clinical relationship, the client functioning as a teacher is markedly problematic in cross-linguistic clinical dyads in which the clinician has not received adequate training elsewhere. The vision of this researcher is that White

clinicians who have made a professional commitment to providing services in Spanish, and who have invested in developing Spanish language proficiency, might be less alone in their path, and might be better supported by the institutions and agencies that train and hire them. With this, Latino/a, Spanish-speaking clients might enter into clinical relationships not to teach, not to reassure, accommodate, or compliment their clinician, but to receive high-quality care from linguistically and culturally competent professionals.

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Appendix A

Human Subjects Review Application

Human Subjects Review Application

Investigator Name: Sara Walker

Project Title: An Exploration of White Mental Health Clinicians' Provision of Spanish-Language services to Latino/a clients

Project Purpose and Design

The purpose of this study is to explore what factors motivate some Spanish-speaking White social workers and psychologists to provide Spanish-language services to Latino/a clients, what experiences they have in providing these services, and what they perceive as the challenges involved in providing these services. The clinicians' ideas around what types of training and support would best position them to manage these challenges will also be explored.

Latino/as comprise the fastest-growing ethnic group in the United States. Individuals of Latino ethnicity have varying degrees of fluency in Spanish, English, and other languages, given factors that include immigration history and level of assimilation. To meet the mental health needs of the segment of this population that is dominant in Spanish, clinicians of many racial identities who have Spanish-language skills, including White clinicians, are providing services in Spanish. The provision of these services is beneficial in that it expands accessibility of services to an underserved population. However, numerous challenges arise when White clinicians who have learned Spanish as a second language, and have varying levels of competency with the language, provide these services. A clinician's clinical training, support within the work environment, and

his or her own internal resources will impact his or her level of preparation to negotiate these challenges. The goal of this study is to collect data that may help clinicians, clinical training programs, and employers to more accurately assess the challenges inherent in cross-linguistic, cross-cultural care, and to work towards managing these challenges, thus improving quality of care for Spanish-dominant clients.

The design of this study will be flexible and exploratory. The researcher will interview 12 to 15 participants who are social workers or psychologists in the San Francisco Bay Area. These interviews will be informed by a set of guiding questions to explore motivations behind White clinicians' choice to do Spanish-language work, experiences and treatment decisions in Spanish-language therapeutic relationships and systems of support around Spanish-language service provision. The researcher will also solicit ideas from the participants as to what training or supports could help them improve the quality of the Spanish-language services they provide. This study will be submitted as a thesis for credit towards the researcher's Masters in Social Work degree, for presentation, and for possible publication.

Characteristics of the participants

The interview sample of 12-15 clinicians will be gathered by a non-random sample of convenience and snowballing. Participants must be White, English-dominant, coordinate English/Spanish bilingual social workers or psychologists who have been conducting clinical work in Spanish with Latino/a clients for at least one year after the receipt of a Master's or Doctorate Degree in Social Work or Psychology. They should have provided Spanish-language services to at least 20% of their total client caseload for

at least one year's time. *Coordinate bilinguals* are individuals who learned two languages in different contexts or at different times in their life. For the purposes of this study, I will limit participation to individuals who learned English as their first language and learned Spanish after age 5. I will ask participants to self-identify their level of Spanish language fluency with the use of a standardized language proficiency chart. The definition of "White", for the purposes of this study, will include all clinicians who self-identify as White or Caucasian, and do not identify as Latino/a in ethnicity. Interviews will take place in person, so the sample will be limited to clinicians currently located in the San Francisco Bay Area.

The Recruitment Process

Potential participants will be identified through convenience and snowball sampling, through networking with personal and professional acquaintances. Because this study focuses on dynamics particular to Spanish-language service provision by those in the dominant culture, interview participants will be limited to those who identify as White or Caucasian. However, the researcher will seek diversity in gender, class, length of time in the field, and nature of employment agency by networking with acquaintances from a variety of sources. Upon identifying or receiving a referral for a potential participant, the researcher will telephone the participant, briefly explain the purpose of the study, as described in the "Project Purpose and Design" section of this document, and ask whether the individual would consider participation. If so, the researcher will screen the potential participant for eligibility, using the questions listed in the "Interview Screening Questions" document that accompanies this application. If the potential

participant is deemed appropriate and willing, the researcher and participant will arrange to meet at a location of the participant's choice. After the interview concludes, each participant will be asked to volunteer names and contact information for additional potential participants. The provision of referrals to additional participants will be entirely voluntary.

Nature of Participation

Interviews will take place at a location of the participant's choosing. All interviews will be conducted in English, with Spanish words or phrases used at the participant's discretion. Interviews will begin with the researcher explaining in brief the purpose of the study, and reviewing informed consent with the participant, including consent to audio recording. Upon receipt of the participant's written consent, the researcher will begin audio recording. First, the researcher will ask the participant a series of short answer questions for demographic and background information. Then, the researcher will guide the participant through each guiding question. Each interview is expected to take approximately 45 to 90 minutes. The researcher will transcribe each audio recording, code the responses, and sort the data.

Risks of Participation

This is a low-risk study for professionals. If participants find that reflecting on their practice as required by participation in this study does raise emotional content, they are encouraged to seek consultation.

Benefits of Participation

Benefits of participation include increased insight for the clinician around the role of his/her Whiteness in his/her Spanish-language work. Participants may enjoy a chance to reflect on the challenges of providing cross-linguistic services. The profession may also benefit from this study because it may help clinicians, clinical training programs, and employers to more accurately assess the challenges inherent in cross-linguistic, cross-cultural care, and to work towards managing these challenges, thus improving quality of care for Spanish-dominant clients.

Informed Consent Procedures

The researcher will provide each participant with an electronic copy of the informed consent by email in advance of the interview. Each participant will be asked to review the informed consent and contact the researcher with any concerns. At the interview's start, the researcher will present the participant with a paper copy of the informed consent. The researcher will verbally state the purpose of the informed consent form, and then ask the participant to review the written form and sign it if he or she is in agreement. The participant will be given a copy of the informed consent form for his or her own records. Participation in this study is voluntary. Participants may withdraw from the study at any time during the data collection process, and may refuse to answer any question without penalty. Should a participant decide to withdraw from the study, he or she is asked to notify the researcher prior to April 1, 2009. Should a participant choose to withdraw from the study, all materials pertaining to him or her will immediately be destroyed.

Precautions Taken to Safeguard Confidentiality and Identifiable Information

After data are collected, interviews will be coded and identifying information will be removed. The researcher's advisor will have access to the data after identifying information has been removed. Should this study be presented or published, precautions will be taken to ensure that participants cannot be identified, including disguising vignettes and quoted comments. All data, including electronic data, will be securely stored. All data and tapes will be kept secure for three years, as required by Federal regulations. After that time, they will be destroyed when the data are no longer needed.

Investigator's Signature: _____ **Date:** _____

Advisor's Signature: _____ **Date:** _____

Appendix B

Human Subjects Review Approval Letter

November 29, 2008

Sara Walker

Dear Sara,

Your revised materials have been reviewed and all is now in order. We are therefore happy to give final approval to this very useful study. I have always had a terrible time learning a language and I must say I am admiring of those English speakers who spend the time and effort to learn Spanish so that they can be of help to Spanish speaking clients. Just today, I was talking to an old friend who is retiring from a professorship at Hunter. I asked her what she was going to do in retirement and she said she was going to learn Spanish. She thinks it's essential to learn Spanish in the US today. I thought of your study.

It will be interesting to see to what extent white privilege attitudes do emerge. I would think that this population would be less prejudiced than those who haven't made themselves available to Spanish speaking clients or take the position that some of our politicians do that they should just hurry up and learn English! But that's what's interesting about research, finding things out!

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Good luck with your study.

Sincerely,

Ann Hartman, D.S.W.
Chair, Human Subjects Review Committee

CC: Fred Newdom, Research Advisor

Appendix C

Interview Screening Questions

Template for screening potential interview subjects:

There are several criteria necessary in order to participate in this study. I would like to ask you a few questions to make sure that you are eligible.

- 1) Do you have a Master's or Doctorate degree in Social Work or Psychology?
- 2) Have you provided Spanish-language clinical services to at least 20% of your clients for at least one year after you received this degree?
- 3) Do you identify as White or Caucasian?
- 4) Do you identify as Latino or Latina?
- 5) Did you learn English as your first language?
- 6) Did you learn Spanish after the age of five?

(In order to participate in this study, the answers to questions 1-3 and 5-6 must be yes, and the answer to question 4 must be no.)

Appendix D

Informed Consent

Dear Participant,

My name is Sara Walker and I am a Masters in Social Work student at Smith College School for Social Work. You are being asked to volunteer for participation in a research project. The purpose of this research is to explore the motivations, experiences, and challenges around White clinicians' provision of Spanish-language clinical services to Latino and Latina clients. This study will be submitted as a Thesis for academic credit. It may also be used for presentation or publication.

In order to participate in this study, you must identify as White or Caucasian in race, and you must not identify as Latino/a in ethnicity. You must have learned English as your first language, and have learned Spanish after the age of 5. You must have completed a Master's or Doctorate Degree in Social Work or Psychology. You must have provided Spanish-language social work services to at least 20% of your total client caseload for at least one year after the receipt of your advanced degree. This interview will take between 45 and 90 minutes. I will record this interview with an audio recording system. I will first ask you a series of short answer questions related to background information. I will then ask you a series of open-ended questions where you will be asked to share your experiences and perspectives. When the interview is complete, I will use the audio recordings to transcribe the interview.

This is a low-risk study for professionals. If reflecting on your practice as required by your participation in this study does raise emotional content for you, you are encouraged to access consultation.

You may benefit from participation in this study in that you may gain increased insight around the role of your Whiteness in your Spanish-language work. You may enjoy a chance to reflect on the challenges of providing cross-linguistic services. The profession may also benefit from this study because it may help clinicians, clinical training programs, and employers to more accurately assess the challenges inherent in cross-linguistic, cross-cultural care, and to work towards managing these challenges, thus improving quality of care for Spanish-dominant clients. You will not receive monetary compensation for your participation in this study.

In the process of this study, your confidentiality will be protected to the extent that is possible. After this interview, I will transcribe the session, and your name and any identifying information will be removed from the transcription. My research advisor will have access to the data after identifying information has been removed. Should this study be presented or published, precautions will be taken to ensure that you cannot be identified, including disguising vignettes and quoted comments. All data, including electronic data, will be securely stored. All data and tapes will be kept secure for three years, as required by Federal regulations. After that time, they will be destroyed when the data are no longer needed.

Your participation in this study is voluntary. You may withdraw from the study at any time during the data collection process, and you may refuse to answer any question

without penalty. After your interview is complete, you may withdraw from the study before April 1, 2009. All materials pertaining to you will immediately be destroyed should you choose to withdraw. Should you have any additional questions or wish to withdraw from this study, you may contact me by email at *email address deleted* or by phone at *phone number deleted*. Should you have any concerns about your rights or about any aspect of the study, you are encouraged to contact me; or, you may contact the Chair of the Smith College School for Social Work Human Subjects Review Committee at (413) 585-7974.

Your signature indicates that you have read and understand the above information and that you have had the opportunity to ask questions about the study, your participation, and your rights and that you agree to participate in the study.

Signature: _____

Date: _____

Appendix E

Human Subjects Review Addendum

March 13, 2009

Dear HSR Committee,

I am writing to propose an adjustment in the inclusion criteria for my study on the experiences of White clinicians in providing clinical services in Spanish. When I drafted my original HSR proposal, I had intended to limit my sample to clinicians who were more experienced in this type of work. With that motive in mind, I set up my inclusion criteria to require that participants must have provided Spanish-language services to at least 20% of their clients for at least one year's time after the receipt of their degree. As my interviews have progressed, I have had some difficulty identifying enough participants who meet these criteria. I have also become interested in the differences between those who have less experience providing clinical services in Spanish and those with more experience; some themes around these differences are already evident in my sample. In order to increase my sample size and gain more data on how level of experience may impact how a clinician thinks about and practices cross-linguistic work, I would like to eliminate the requirement that participants must have a specific amount of experience in providing services in Spanish. Instead, I would like to include a range of providers in the sample, from recent graduates of Social Work and Psychology programs who have been providing Spanish-language services for just a few months, to seasoned professionals who have spent much of their careers doing this work. The revised

requirement would be, simply, that the provider must have provided services in Spanish after completing their professional training.

In order to implement this change in inclusion criteria, I will revise the questions that I ask of potential research participants during the screening process. A revised version of the screening questions accompanies this document. I will also be able to contact a number of clinicians who have expressed interest in participating in the research, and meet all criteria except that they originally did not have enough experience to qualify. I would notify them of the change in inclusion criteria and ask if they might re-consider participation.

This revision in participant criteria will provide data that will help me to hypothesize upon how clinicians' experiences and work may change as their careers progress. I believe that this change will not compromise the quality of the study. I will still be working with a professional sample of clinicians who have graduated from Social Work and Psychology programs, so I do not believe that the participant population will change enough that it will impact the interview process in any way. My expectation is that adjusting my inclusion criteria, in accordance with this proposal, would increase my sample size and the diversity of my sample without compromising the quality of the study. I look forward to your response.

Thank you,

Sara Walker

Appendix F

Human Subjects Review Addendum Approval Letter

Dear Sarah,

Thanks so much for keeping us up to date. Your changes are fine and we appreciate the inclusion of your new screening questions. Laurie Wyman will print your email and deposit it in your permanent file so you won't have to do anything else. I hope this increases your sample. Finding participants is often the toughest part of the whole process.

Sincerely,

Ann Hartman, D.S.W.

Chair, Human Subjects Review Committee

Appendix G

Interview Screening Questions (Revised)

Template for screening potential interview subjects:

There are several criteria necessary in order to participate in this study. I would like to ask you a few questions to make sure that you are eligible.

- 1) Do you have a Master's or Doctorate degree in Social Work or Psychology?
- 2) Have you provided Spanish-language clinical services after you received this degree?
- 3) Do you identify as White or Caucasian?
- 4) Do you identify as Latino or Latina?
- 5) Did you learn English as your first language?
- 6) Did you learn Spanish after the age of five?

(In order to participate in this study, the answers to questions 1-3 and 5-6 must be yes, and the answer to question 4 must be no.)

Appendix H

Informed Consent (Revised)

Dear Participant,

My name is Sara Walker and I am a Masters in Social Work student at Smith College School for Social Work. You are being asked to volunteer for participation in a research project. The purpose of this research is to explore the motivations, experiences, and challenges around White clinicians' provision of Spanish-language clinical services to Latino and Latina clients. This study will be submitted as a Thesis for academic credit. It may also be used for presentation or publication.

In order to participate in this study, you must identify as White or Caucasian in race, and you must not identify as Latino/a in ethnicity. You must have learned English as your first language, and have learned Spanish after the age of 5. You must have completed a Master's or Doctorate Degree in Social Work or Psychology. You must have provided Spanish-language social work services after the receipt of your advanced degree. This interview will take between 45 and 90 minutes. I will record this interview with an audio recording system. I will first ask you a series of short answer questions related to background information. I will then ask you a series of open-ended questions where you will be asked to share your experiences and perspectives. When the interview is complete, I will use the audio recordings to transcribe the interview.

This is a low-risk study for professionals. If reflecting on your practice as required by your participation in this study does raise emotional content for you, you are encouraged to access consultation.

You may benefit from participation in this study in that you may gain increased insight around the role of your Whiteness in your Spanish-language work. You may enjoy a chance to reflect on the challenges of providing cross-linguistic services. The profession may also benefit from this study because it may help clinicians, clinical training programs, and employers to more accurately assess the challenges inherent in cross-linguistic, cross-cultural care, and to work towards managing these challenges, thus improving quality of care for Spanish-dominant clients. You will not receive monetary compensation for your participation in this study.

In the process of this study, your confidentiality will be protected to the extent that is possible. After this interview, I will transcribe the session, and your name and any identifying information will be removed from the transcription. My research advisor will have access to the data after identifying information has been removed. Should this study be presented or published, precautions will be taken to ensure that you cannot be identified, including disguising vignettes and quoted comments. All data, including electronic data, will be securely stored. All data and tapes will be kept secure for three years, as required by Federal regulations. After that time, they will be destroyed when the data are no longer needed.

Your participation in this study is voluntary. You may withdraw from the study at any time during the data collection process, and you may refuse to answer any question without penalty. After your interview is complete, you may withdraw from the study

before April 1, 2009. All materials pertaining to you will immediately be destroyed should you choose to withdraw. Should you have any additional questions or wish to withdraw from this study, you may contact me by email at *email address deleted* or by phone at *phone number deleted*. Should you have any concerns about your rights or about any aspect of the study, you are encouraged to contact me; or, you may contact the Chair of the Smith College School for Social Work Human Subjects Review Committee at (413) 585-7974.

Your signature indicates that you have read and understand the above information and that you have had the opportunity to ask questions about the study, your participation, and your rights and that you agree to participate in the study.

Signature: _____

Date: _____

Appendix I

Interview Guide

Demographic/Background Questions:

- 1) What would you like to be called during this interview?
- 2) What is your age?
- 3) How do you identify in terms of gender?
- 4) How do you identify in terms of race?
- 5) How do you identify in terms of ethnicity?
- 6) Please rate your level of Spanish competency according to this scale. (See Classification of Language Proficiency below).
- 7) Where and when did you learn Spanish?
- 8) Where and when did you receive your clinical training?
- 9) What training, if any, did you receive from your clinical training program in providing Spanish-language services?
- 10) After you received your clinical degree, for how long have you provided Spanish-language clinical services?
- 11) Approximately what percentage of the total population served by your agency of employment is dominant in Spanish?
- 12) Approximately what percentage of the population on your caseload is dominant in Spanish?
- 13) What training or support, if any, do you receive from your agency of employment in providing Spanish-language services?
- 14) What training or support, if any, have you received outside of your clinical training program and your agency of employment in providing Spanish-language services?

Guiding Interview Questions:

- 1) What does it mean to you to be a White person who speaks Spanish?
- 2) Why do you choose to offer Spanish-language services?
- 3) What are the challenges, if any, that you encounter when you provide Spanish-language services?
- 4) How do your Spanish-dominant clients respond to you as a Spanish-language service provider? Do you think that this differs from how Latino/a Spanish-language service providers are responded to by their clients?
- 5) Have you ever referred a Spanish-dominant client who was assigned to you to a clinician who spoke Spanish as their native language, or wished you could? If so, why?
- 6) Have you ever thought that your being a White clinician was advantageous in your treatment of a Spanish-dominant client? If so, why?

- 7) How does your supervisor respond to you as a Spanish-language service provider? Do you think that this differs from how Latino/a Spanish language service providers are responded to by their supervisors?
- 8) Are there any differences in the quality of the Spanish-language services that you provide, in comparison with the English-language services that you provide? If so, what accounts for these differences?
- 9) What additional support or training, if any, would help you improve the quality of the Spanish-language services that you provide?

Classification of Language Proficiency

Level Description:

5 Equivalent to an educated native speaker of the target language

4 Can persuade, negotiate, counsel, represent a point of view

3 Can hypothesize, express and defend opinions, handle unfamiliar situations

2 Can describe and narrate in past, present, and future time; handle a situation with a complication

1 Can create with language, ask and answer questions, handle simple survival situations or transactions

0 No functional ability; only isolated words

Note. Individuals are rated at the level they are able to maintain during extended conversations. A plus sign would be used to denote that a higher level of functioning is possible for short periods of times.

N. Patrizio-Quinones, personal communication, September 15, 1999. As cited in Biever, J.L., M. Castaño, T., de las Fuentes, C., González, C., Servín-López, S., Sprowls, C., & Tripp, C.G. (2002). The role of language in training psychologists to work with Hispanic clients. *Professional Psychology: Research and Practice*, 33(3), 330-336.