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## The role of mother tongue in therapy for limited English proficiency individuals : sense of self, emotional expression and the therapy relationship

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Maria Plazas  
The Role of Mother Tongue in  
Therapy for Limited English  
Proficiency Individuals: Sense of  
Self, Emotional Expression and The  
Therapy Relationship

**ABSTRACT**

Language fundamentally shapes an individual's identity and worldview. It is a principal component in the development of self, identity, and how relate with others. Individuals with Limited English Proficiency (LEP) who immigrate to the U.S and learn English as adults must learn a new language. This process allows the individual to adapt to and survive in their new environment while they simultaneously experience a sense of loss of the original self and mother tongue. When these individuals seek treatment, they may not have a choice in the language used, and internally, may move between languages. Theory suggests that this can reflect an adaptive process of adjustment or maladaptive process of avoidance. The current exploratory study focuses on the experiences of LEP individuals in order to understand one's emotional expression and sense of self, as both affect the therapy process and relationship. The use of English for LEP individuals appeared to be related to reduced emotional expression and sense of self, as participants would have preferred to use their native language regardless of topic. Findings also suggested that use of English for LEP individuals was associated with reduced satisfaction with the clinician and reduced trust. It appears that feeling understood by the clinician and feeling like that the clinician had an ability to connect to the client's true self were important factors.

**THE ROLE OF MOTHER TONGUE IN THERAPY FOR LIMITED ENGLISH  
PROFICIENCY INDIVIDUALS: SENSE OF SELF, EMOTIONAL EXPRESSION AND  
THE THERAPY RELATIONSHIP**

A project based upon an independent investigation,  
submitted in partial fulfillment of the requirements  
for the degree of Master of Social Work

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2015

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This thesis is dedicated to my husband Andy, whose love, support and encouragement has helped me achieve my goals and dreams.

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## **CHAPTER I**

### **Introduction**

Language is fundamental in shaping an individual's identity and worldview, and it is a principal component for the development of self. Children learn how to understand the world and how to relate with others through their caregivers, and these experiences are narrated and internalized using the individual's language of origin. Language itself is a complex process, which includes verbal and non-verbal communications and allows individuals to make sense of their life experiences and build relationships with others.

Individuals with Limited English Proficiency (LEP) who immigrate to the United States and learn English as adults must learn a new language, and the process of identity and self-development reemerge in the second language. This allows the individual to adapt to and survive in their new environment. Thus, a new language represents a different identity in a foreign culture. The individual who is in this immigration process is simultaneously experiencing a sense of loss of the original self that is associated with their mother tongue. In an effort to adapt to a dual experience of self, the individual may make sense of experiences using one language over another. However, the individual continues to have access to both languages and both senses of self, both in the world around them as well as in their internal world.

Since languages have nuances between them, an individual may express themselves in two languages with similar words and concepts, but the content may have emotionally different connotations. It is important to take into account that each language was learned in different

contexts and times, which allows the individual to use different symbolic codes to express the same experience. However, there are patterns to how an individual uses language in discussing their experiences and connects language to their emotional content. For example, the second language may be emotionally connected to a sense loss and grief in the immigration process and the individual may choose to speak the native language to avoid this loss.

The implications for language choice and emotional expression when an individual seeks therapy are far reaching. It is expected that there will be more LEP individuals in the United States as time progresses, with significant mental health needs related to their immigration and adjustment to the US. It is imperative that social workers understand the experiences of LEP individuals broadly as well as how experiences of loss of their home country, their identity, and their native language during immigration shape the therapy process and relationship. In the context of therapy, LEP individuals may move between languages, and this can reflect an adaptive or maladaptive process. For example, individuals may express their emotions in their mother tongue as a way to connect with and share parts of their native self; alternatively, an individual may express an experience in his or her mother tongue, reflecting a desire to avoid speaking of challenging experiences that occurred during their immigration process. Language use in therapy with LEP individuals is an understudied area of social work practice and has implications for training. As such, this study may help clinical clinicians to improve counseling services and programs focused on the needs of minority and multicultural LEP individuals.

The current study aims to better understand the role of language in emotional expression and sense of self as they, in turn, affect the therapy process and the therapy relationship. This study asked LEP clients to describe how they process their emotions, their sense of self, and their perception of their relationship with their clinician. It was the study's goal that LEP individuals

would clarify if a second language in therapy accurately represented emotional and personal experiences, or if a second language inhibited emotional expression and development of a strong therapy relationship. The current study is focused on the experiences individuals with LEP since the majority of the literature on bilingual therapy lacks the perspective of LEP individuals.

This study's questions are as follows: What is unique about therapy processes for LEP clients who have learned English as adults? Specifically, how do clients feel about their ability to express their emotions? How does emotional expression connect to the therapy relationship? The inspiration for this study came from my own experience as a LEP individual who immigrated to the United States and learned English as adult. During this process, I noticed that in order to adapt to my new environment, a creation of a new identity was needed. I quickly realized that, within my new identity, I not only needed to learn a new language, but an entire way of engaging in relational behavior. While I found that this new identity developed in parallel with my core native self, I also noticed that I was required to engage in code switching, or jumping between these versions of self, because each identity lacked the capacity to translate aspects of my experience. I found that the same communication in one context of self communicated different things. For example, excitement in my native verbal and non-verbal communications could be read as "uncontrolled" in my second language context. This experience of self as I was learning to be a clinician evoked my interest of how other LEP individuals are experienced by others when they seek treatment, and I became curious about the impact of mother tongue and concept of self on treatment processes (e.g., use of defense mechanisms) and on diagnostic processes as well (e.g., clarification about what is actually a defense mechanism).



## **CHAPTER II**

### **Literature Review**

Individuals with Limited English Proficiency (LEP) face several challenges when entering therapy. The current study will focus on the role of language in emotional expression and the development of the therapeutic relationship. LEP individuals who have experienced recent immigration and learned English as adults have special needs when presenting to treatment, and these are often not fully understood. However, clinicians need to be prepared and fully understand the role of language in shaping how somebody engages in therapy. In the following pages, I review literature that discusses (a) the role of language in development; (b) the development of a new self when learning a second language; (c) the role of language in emotion; (d) therapy issues with LEP clients.

#### **The Role of Language in Development**

Language shapes psychological development and is fundamental in shaping an understanding of the self and the world. It is influenced by the kind of connections that individuals have with caregivers and by early life experiences (Canestri & Reppin, 2004). Language transforms an individual's perception into ideas and encodes meaning (Greenson, 1950). It is intrinsically connected to a person's culture and, as such, has characteristics that are uniquely connected to, and shaped by, the language's lexical, syntactical, phonemic, semantic and ideational components (Vygosky, 1962). Language and communication are also indicators of personal and social identity. Brown and Levinson (1979) suggested that language, in addition to

being an encoding and decoding process, shapes how one understands and develops their sense of self, both individually and in relation to larger society.

In addition to spoken language, an important element of language is the associated nonverbal communication including tone of voice, gestures, body expressions, and posture (Buxbaum, 1949). These methods are important ways to communicate feelings, given that this experience is paired with verbal communication of emotions that are learned with caregivers in early stages of development. Canestri et al. (2004) highlighted the importance of non-verbal communication in early development. On a panel with colleagues, Canestri and Reppin reflected on how language is paired with the sound of the caregiver's voice, which can calm and "hold" the infant, and how the infant's learning process of the native language will always depend on the relationship between mother and infant. In essence, they argued that verbal and non-verbal experiences with early caregivers are likely to dominate the associated emotional experiences.

Thus, it is in the verbal and nonverbal language of early childhood—"mother tongue"—that early experiences are encoded. The mother tongue is the language that registers the sounds and words of the client's developmental experiences, primitive needs, relational experiences and early memories. As such, primary language shapes how human beings construct themselves and the world and how they communicate with each other. Given these functions, language also has tremendous transformational and regulatory power (Pérez Foster, 1996).

The above-described processes, however, become complicated when an individual is speaking a second language that is learned in adulthood. In itself, speaking two languages may strengthen cognitive and adaptation skills and is associated with the development of different linguistic processes, meanings, and affective organizations (Pérez Foster, 1996). However, the

implications of learning a second language in adulthood for individuals with LEP are far reaching.

Theory and research suggests that bilingual individuals, specifically LEP individuals, have multiple complex social/relational processes and representations of self that are associated with each language. Pérez Foster (1996) proposed that bilingual individuals have an inherent duality as part of their bilingual/bicultural lives. She argued that bilingual individuals have two sets of coding and decoding experiences and feelings that are associated with two different experiences and understandings of the self that are constructed, organized and experienced in each language. Each self-representation evokes a different culture, developmental experience, and personal and social identities. The implications of these developmental processes are far reaching for individuals who learn multiple languages, either during childhood or in adulthood, and are explored further below.

### **Second Language and a New Self**

As outlined by Pérez Foster (1996), bilingual individuals may experience a dual reality that moves between each language's cognitive and affective experiences. When an LEP individual learns a second language later in life, and when this occurs within an immigration experience, there appears to be a construction of a new "adaptive" self (Pérez Foster), which differs from the native-language self. This adaptive self emerges within a complex and challenging context that likely affects the individual's sense of their "true" self (associated with the primary language) and capacity for expression.

In fact, when an individual speaks more than one language as an adult, they develop the "phenomena of language independence" (Clauss, 1998; Marcos & Urcuyo, 1979; Pérez Foster, 1992). This refers to a condition in which an individual learns and practices two separate

representational and thinking processes. Thus, bilingual individuals possess dual language codes in which they can think, be, and communicate (Marcos et al., 1979). Since each language has its own experiential histories and coding procedures (Alessi, 2000), this language independence is essentially associated with a dual experience of the self. This means that an individual may have the ability to encode and report two similar descriptions of an experience with different symbolic codes to represent the same experience.

Is evident that LEP individuals' difficulty with proficiency and the associated immigration and acculturation processes have a direct effect on the creation of the adaptive self in the new language. Imberti (2007) explained that when LEP individuals immigrate to this country, they start a process that requires the use of new language—which includes a new thinking process—and as a result, their worldview and identities transform as well. She suggests that the second language and the new self do not represent the core self, culture, and background. This means that bilingual speakers who learn English as adults and immigrated as adults develop a dual linguistic self, each with different thoughts, emotions and perceptions that were learned in very different contexts, cultures, and times (Pérez Foster, 1992).

Akhtar (1991, 1994) explains how the immigration and corresponding language processes may influence the experience of self. He argues that mental representations of family, land, and identity can change in adult immigrants. According to Akhtar, immigrants have significant emotional experiences around grief and loss as they try to engage in a new culture and adapt to a new environment while creating a new self in a chaotic experience. The magnitude of language, cultural and social differences between their native country and the United States can increase social isolation, dependence, fear of failure, and lack of self-esteem. Adult immigrants may also face medical illness, sadness, existential crises and shame. As a result, adopting a new

language and culture is a traumatic experience that affects one's sense of cultural belonging and identity (including their race and other intersectional identities), and therefore has a direct impact on the assimilation process.

Ainslie (2009) similarly explored the immigrant's construction of self and explained how it relates to social class. He argued that immigrants experience loss of mobilization as part of the adaptation process, specifically with regard to language, social class, status, socioeconomic access, and education. That disempowering process can lead to feelings of frustration, anger and devaluation. He argued that it is impossible for immigrants to disconnect from their core selves; and therefore, their new adaptive processes include (a) the influence of their original social contexts and class identity; (b) generational class anxieties (e.g. families that have been in wars, in power, privilege, poverty); and (c) narcissistic vulnerabilities (latent fear of failure). This means that the creation of a new self requires significant emotional effort because it is created in the emotional context of grief and loss. This process that is in the context of vulnerability reduces the capacity of adaptation and therefore the ability to succeed. He emphasizes the importance of differentiation between immigration process and pathology in therapy, as some immigrants are in an identity crisis, are building a new self, and are using a language that does not represent their emotion and earlier developmental experiences.

It is evident that immigration and acculturation processes can be traumatic experiences that may interfere with LEP individuals' process of adapting to their new environments. Pérez Foster (1992) explained that some immigrants may have the tendency to "split" their adaptive experience, seeing their old country as "good" and their new country as "bad," while other individuals may integrate the good and the bad of both countries. Immigration may also be associated with grief and loss because it represents the limitation of expression, the loss of part

of the self and culture, the loss of class and privilege (for some), and the changes/loss of other cross-cultural experiences. Additionally, racism and lack of intersectional acknowledgment may also affect the immigration and adaptation process of an LEP individual and shape how the adaptive second self develops.

In summary, when an adult is learning a new language as a result of immigration, the individual must create a new sense of self, different relational experiences, different emotional meanings and different representations of developmental contexts in order to adapt and survive in the new environment. Two selves may also imply the use of “switching” as the individual needs to live between different internal selves, cultural customs, and relational processes.

### **Emotional Expression and LEP Individuals**

LEP individuals who are not fully proficient in their second language may be unable to fully express the emotional content and experiences that are related to their native culture and early development in English. Lack of expression in English might constrain the ability to find the exact translation (if it exists) or the exact meaning of an idea; this lack of expression might reduce the capacity to regulate emotions in the second language. LEP individuals are in the dual process of learning and expressing two languages, each with its own organizational and emotional system. Emotions, tones, and meanings can be difficult to translate, and the new language can be associated with challenging experiences or overall deficit as the second language is not proficient.

Several scholars built upon the idea of a dual experience of the self, or the development of a second adaptive self, and discussed the associated emotional experiences, particularly in the context of immigration. Pérez Foster (1992) suggested that during the immigration process, a bilingual LEP adult is forced to develop a new sense of self as a means of survival and will not

be able to completely express their inner emotions, which requires using a new language that does not reflect their relational processes and culture. She argued that this mismatch between the native language and the new country's language is associated with anxiety, loss, and grief. It represents the grief from one's motherland including culture, social status, and language, in addition to the loss of the true self and the creation of a new transformative and adaptive self. The grief process interacts with the basic difficulty of expressing emotions in a new language that lacks the developmental associations and complicates emotional expression in multiple ways.

For example, an LEP individual may have an easy time using the second language in everyday conversation but may need to speak in the primary language when dealing with death or trauma in order to fully experience and express the emotion. Alternatively, however, an LEP individual may prefer to speak their primary language most of the time but may choose to speak the new language when dealing with death or trauma to avoid and minimize the emotional impact of the specific content. This emotional process is also complicated by the fact that being in a new country may result in idealization (experiencing the home country or the new country as ideal or perfect) and disempowerment (change or downgrade social class, socioeconomic and professional status) that can lead to feelings of frustration, paranoia, anger and devaluation.

In summary, emotional expression may result in a complex process for LEP individuals in therapy, especially if their clinician does not speak the client's mother tongue or understand the client's culture and immigration processes. This means the bilingual LEP client may not connect, as he would like to his true self and emotional expression.

### **Mother Tongue, Language Proficiency, and Increased Emotional Expression**

Given that language is a foundational component of affective identification and expression, researchers have begun to explore how the experience of bilingualism shapes these affective processes. Kolers (1963) demonstrated in a number of psycholinguistic studies using TAT (Thematic Apperception Test) that words expressing emotional concepts produced very dissimilar associations between English and a client's mother tongue. However, words referring to cognitive concepts produced similar associations between English and a client's mother tongue. He concluded that each language provides data and learned perceptions and emotions in the brain in different way. This study suggest that bilingual LEP clients' emotional and identification processes, which were originated in early stages of development with the primary caretaker in Spanish, will become the primary language of choice to express those feelings and experiences.

Marcos, Urcuyo, Kesselman, and Alpert (1976) also explored emotional expression with information-processing mechanisms involved in the secondary language that may function as a barrier to the emotional expression of the person. Study participants included 10 Puerto Rican individuals (6 men and 4 women) between 21 to 42 years old whose primary language was Spanish. Participants were in the country for an average of 18 years and were diagnosed with schizophrenia without any organic brain disorder. During the study, the individuals were recorded - CCTV in English and Spanish. Marcos et al. observed that clients were emotionally distant during the therapy and displayed difficulties making emotional contact with their clinicians when speaking in English. The researchers also noticed that switching between English and Spanish languages affected the content of the interview. English language imposed an additional cognitive and emotional difficulty on the clients because they were challenged



organizing their thoughts and feelings. On other hand, Spanish language allowed participants to express and engage with their emotions. The study concluded that a language barrier likely affects the therapeutic process because the use of a second language may lead to disconnection from emotions.

Although language can successfully communicate certain components of experiences, elaboration and emotional expressions are much richer when using the mother tongue. Javier, Barroso, and Muñoz (1993) conducted a mixed method study that examined linguistic expression and memory organization in bilingual individuals. Specifically, the researchers were curious as to how bilingual individuals narrate the same experiences in different languages. They studied five English proficient individuals—three females and two males between 29 and 66 years old—whose primary language was Spanish. All participants completed high school and some engaged in some college education. Barroso et al. found that experiences expressed in the mother tongue were more elaborate with a higher level of imagery. Findings also suggested that emotional content and emotional events were more organized and intense when expressed in the mother tongue. In contrast, the study found that expression of experience is more abbreviated when using the second language, and concluded that the second language can successfully express emotions and experiences, but that these expressions are in “shorter versions.” It is important to note that this research suggested that each language more accurately can express the linguistic experience associated with the linguistic context in which the event happened.

Since mother tongue is associated with more organization and intensity of emotions, it also appears to evoke more negative memories, rejection, and neglect than the second language. Gonzalez-Reigosa (1976) explored emotional reactions of bilingual individuals when expressing taboo words in their two languages. The subjects were 80 individuals whose primary language

was Spanish. Forty individuals were high in English proficiency and 40 were low in English proficiency. All individuals were Spanish-English bilingual male students attending college. Gonzalez-Reigosa found that taboo words elicited higher anxiety when expressing them in the native language, and suggested that mother tongue words linked to the primitive and emotional world of native language may evoke negative memories, rejection and mistreatment. However, code switching and/or use of a second-language made it easier to speak about uncomfortable issues for a longer time. This finding seems to imply an emotional detaching function intrinsic in the use of the second language.

The intensity of emotional reaction that mother tongue might evoke is also due to language proficiency. Lambert (1956) conducted an experimental study and observed linguistic behavioral differences at different stages of language acquisition in 3 groups of 14 bilingual individuals. The first group consisted of American individuals who learned French language as adults, the second group consisted of American undergraduate students majoring in French (average proficiency), and the last group consisted of American graduate students majoring in French and mature native French individuals who use English on a daily basis (high proficiency). Lambert found that richness of associations (“meaningfulness”) was related with proficiency, and that proficiency is related to emotional responses and choice of language to use. He also observed that proficiency and word order might affect emotional responses because proficiency is related to more emotional association. This finding seems to suggest that LEP individuals will not choose English to communicate “meaningful” emotions or “provocative” responses.

It may be the case that a particular language itself is associated with greater emotional expression, which requires further exploration as we understand the process for LEP individuals. Gutfreund (1990) examined the effects of the mother tongue and the second language on

emotional experiences in 80 bilingual (Spanish and English) individuals, half of whom spoke English as their native language and half whom spoke Spanish as their native language. Sixty women and 20 men, with an average age of 29 years old, learned their second language after the age of 5 years old. Despite the differences in their original language, both native English and native Spanish individuals expressed more affect in Spanish. Gutfreund concluded that overall, the Spanish language evoked more affect than English language. As such, native Spanish speakers may have results that are dramatically different than their true emotional experiences when evaluated in the second language. The study suggest that is important not only to understand the ways that different languages allow for a different expression of emotion, but also to consider the importance for LEP individuals to be evaluated in their mother tongue as therapeutic process appears to be more meaningful in the secondary language.

The above empirical studies suggest that the language of choice for emotional expression is the mother tongue and that the second language can be associated with emotional disconnection. Therefore, the mother tongue likely provides a richer emotional landscape, offering more organized content and intense connection with emotions. Since the mother tongue is connected to a more intense emotional experience, it allows for greater access to negative memories and those associated with rejection and neglect. It possible that mother tongue evokes stronger emotions, memories, and clearly organization because it is associated with greater levels of proficiency. Based on this reviewed research, there are clear implications for the use of language and emotional expression in therapy, and we must consider how issues of language influence the therapy relationship and diagnosis.

## **Second Language and Therapy**

When individuals learn a second language as an adult, they develop a second set of mental representations with words and symbols that do not always represent the same meanings as they do in the first language. Bilingual individuals maintain dual language codes in which they can think, behave and communicate. They have the ability to use two similar narratives and different symbolic codes to express the same experience—an ability that may affect their experience in therapy (Clauss, 1998; Foster, 1992; Marcos et al., 1979).

Given the emotional challenges faced by LEP individuals who immigrate as adults, it is critical for social workers to be mindful about the process of loss and dual experiences of self and how it may have repercussions in therapy. As described above, childhood emotions and regulation abilities are encoded in the core self, and more recent experiences are encoded in the new self. Thus, the second self, who communicates in the second language, can either be used by the client defensively to protect the individual from trauma and anxiety or can be used adaptively to make sense of the individual's current experience in the world. This (often unconscious) choice reflects the concept of “splitting.”

In social work practice, “splitting” refers to the process of detaching the self from difficult emotions and experiences in order to protect the self from pain (Kokaliari, Catanzarite, & Berzoff, 2013). It is in some ways functional; it is used to avoid stress and increase mental functioning around memory, focus, and expression. Greenson (1950) stated that splitting, when using the second language, can also offer an opportunity of therapy adaptation: a new functional self and a less conflicted identity that helps the client to establish new relationships and cope with intrapsychic conflicts. However, splitting can also be maladaptive, especially when it

represents disconnection from the self and others and a distorted view of reality (Costa & Dewaele, 2012).

Javier (1989) suggested that linguistic shifting and linguistic splitting can be both adaptive and maladaptive. He offered three reasons for linguistic shifting: (a) as a coping mechanism to avoid stress and maximize psychological functioning; (b) as a way to properly express oneself because expressions may not have a literal translation; and (c) as a way to escape to the social beliefs and experiences of the native language and culture. He also suggested that linguistic shifting and splitting might depend on the bilingual LEP client's conscious or unconscious decision to communicate their thought content that is associated with one or the other language.

Splitting and shifting in LEP individuals is further complicated by issues of proficiency. For example, an individual's shifting may be a function of language proficiency alone when words do not have an exact translation or meaning in the other language; this kind of splitting may not be a defense mechanism. In therapy, splitting and shifting in LEP individuals may be misinterpreted; this act may represent a direct connection with their emotional experience rather than an apparent defense mechanism to avoid painful material.

Splitting and shifting may also vary if the clinician is bilingual and shares the client's cultural background. Alonzo (2009) explored how sharing the mother tongue between clinician and client builds trust, connection and treatment engagement. She performed a qualitative study with bilingual clinicians who performed therapy in a language other than the language used in their qualified training. He studied 13 bilingual clinicians who were at least 22 years old and who worked with at least 5 clients in their caseload. Some clinicians were native Spanish speakers and others were native English speakers. All clinicians were from New York and New Jersey and

were working with minority populations. Clinicians were asked about their therapy relationship with their clients. The clinicians reported that their clients had stronger sense of self-esteem in their mother tongue because they learned a second language as adults. This study concluded that English as a second language is commonly used by bilingual clients when with a bilingual therapist for splitting purposes to regulate painful material. These authors argue that mother tongue usage in therapy has positive implications as individuals feel trust, cultural connection, and willingness to engage and communicate in therapy. The study also concluded that bilingual clinicians are more able to develop empathy and intimacy during therapy with bilingual clients.

In this vein, bilingual LEP clients may feel alienated from the clinician's cultural context if they do not feel understood or able to communicate their feelings or experiences across cultures and languages. Sprowls (2002) argued that the lack of translation for certain ideas and the increased effort needed to convey these ideas in another language shows how therapy is influenced by cross-cultural difficulties and can increase frustration for the client and the clinician. Javier (1989) suggested that LEP clients may experience alienation with the clinician if they are not able to feel understood or able to communicate their feelings associated with the original self and the adaptive self. Similarly, Verdinelli (2006) suggested that confusion in communication between the clinician and the client, including misinterpretation, pronunciation, accent, can interrupt the flow of therapy and have implications for agreement on the goals of treatment. There are implications for this shifting between selves in therapy, particularly for the therapy relationship.

The connection between clinician and client may also be influenced by language. Bowker and Richards (2004) explored the meanings and process that English-speaking clinicians gave to their experiences when working with non-native English speakers clients. Bowker et al.

interviewed 10 participants: five psychoanalytic clinicians, four psychodynamic counselors, and one clinician who practiced as both clinician and counselor. All clinicians were first language English speakers who had experience conducting therapy in English with a client who speaks English as a second language. A qualitative methodology was chosen, using semi-structured, audiotaped interviews. Their results revealed that they had significant personal concerns around bilingualism, communication problems, and cultural differences rather than linguistic differentiations. Two main themes emerged in relation to those concerns: separation and distance, and connection and extra effort.

The findings of the Bowker et al. (2004) study suggest that English proficiency levels may cause speculation about a client's capacity to work at deeper levels and the client's ability to use and understand interpretation. Clinicians explained that clients with a low English proficiency level were affected by a sense of low self-esteem and sense of disadvantage, as evidenced by frequent apologies about their proficiency levels. However, these clients' self-evaluations were based on real relational processes. These clinicians also reported feelings of "distance" when the client was less proficient; and they had strong feelings about their client's emotional detachment at some stage of the work. These clinicians also noted feeling less confident about being able to empathize with the client when the language or culture of origin was less familiar. Vastly more difficulties in communication were observed when the client had a marked foreign accent. However, these clinicians also made an extra effort to listen carefully to and connect with a bilingual client using verbal and non-verbal communication. Thus we see that assumptions about level of capacity of an LEP client have direct implications for the nature of the connection between the client and the clinician.

Bowker et al. (2004) found that some clinicians believed it was impossible to separate mother tongue from developmental, cultural and immigration issues, and these clinicians identified cultural misunderstanding as a point of concern regarding a rupture in the therapy relationship. Clients may frequently feel alienated in their new country as a consequence of the difficult process of learning a new language and immigration; this perception of alienation, at times, extended into the therapy room. Based on these issues, clinicians need to be aware of power issues in therapy, as they are the “native speaker.”

Bowker et al.’s (2004) identification of separation and connection as major areas of concern in therapy with LEP individuals is critical. The clinicians reported that language and cultural differences can create a sense of separation and those feelings may reflect the experiences of their clients in therapy. Language also can represent a sense of separation or detachment in therapy because bilingual individuals tend to acquire two separate and coexisting linguistic organizations. When the client shifts into the non-native language, the clinician can likely conclude that connection to emotions and core self is limited. In this case, it may be that the use of “splitting” or “shifting” is in fact a defense mechanism. This is consistent with Krapf’s (1955) argument that the choice of using the second language in therapy is the result of a client’s need to maintain control of painful psychic material. Therefore, the second language may be primarily used in therapy as an instrument to control conflicts, painful memories and self-knowledge.

Kokaliari et al. (2013) also stated that different languages express different identities and experiences and explored how language is important for splitting when dealing with trauma in therapy. They implemented a qualitative study (N=101) that explored clinicians’ appreciations of the role of language in therapy with bilingual clients. Their study included 84 females and 17



males, with an average age of 46 years old. Participants were highly educated multicultural and multilingual clinicians who completed questionnaires and interviews; they reported 20 different nationalities and included 19 monolinguals, 30 bilinguals, 22 trilinguals, 20 quadrilinguals, and 11 pentalinguals. The results suggested that monolingual clinicians were less able to develop empathy and intimacy during therapy, although they were also less prone to collude with clients. “Multicultural” clinicians had more access to their client’s emotional range and freedom of expression and were more accurate in managing cultural identities. They also observed how clients “switch back and forth between primary and secondary languages” in therapy and how all partial descriptions of stories and experiences occurred when speaking in the second language. This process of splitting appears to be adaptive, and the study suggests that “multicultural clinicians” were able to support this type of splitting effectively.

Kokaliari et al. (2013) concluded that language issues in psychotherapy are particularly critical with regard to the use of splitting, access to emotions, and the accuracy in the narratives used. Their results suggest that use of the mother tongue can provide access to strong affects and increase therapeutic alliance, while the second language can be useful for the use of splitting when dealing with trauma. However, they emphasize that narratives are frequently incomplete when the second language is used. Finally, this research demonstrates that each language can express different values or identities, as bilingual clients have experiences in different languages and cultures.

Based on the literature reviewed in the above paragraphs regarding the multiple functions of splitting, emotional expression, and connection to native language self, there are significant implications for diagnosis and expression of pathology with regard to language. For example, Connolly (2002) explained that identity splitting may be confused with psychotic experiences

and may affect diagnosis. Similarly, the struggle and anxiety in the process of adaptation to a new environment may result in a new cognitive overload and may lead to behaviors that appear to be mental health symptoms. Some clients may be facing rejection from their new culture, and it may influence their self-confidence and their ability to function competently, and this can be interpreted as a difficulty of the client as opposed to a cultural adaptation process.

Segovia-Price, and Cuellar (1981) studied the effect of language on the expression of psychopathology with variables of verbal fluency, acculturation, and self-disclosure. They studied 32 participants who were bilingual Mexican-American. There were 14 females and 18 males, ranging in ages from 24 to 48 years old. Participants did not show any evidence of organic brain disorder, alcoholism, or schizophrenia prior to the study. Participants were videotaped answering Spanish and English interviews, and the Brief Psychiatric Rating Scale was used to establish participants' levels of psychopathology expressed during each meeting. The results showed that the clients expressed more symptomatology/psychopathology during the Spanish interview, and their verbal fluency, acculturation, and self-disclosure were found to be significant predictors of expressed psychopathology. The study concludes that significantly greater pathology was found in the Spanish interviews, and explores several explanations to this finding. These findings implied that language has an effect on the expression of psychopathology in bilingual bicultural clients and the variables of verbal fluency, acculturation, and self-disclosure can collectively predict this effect. The study also suggested that the process of adapting to a new environment can be an overwhelming process and that use of the mother tongue during therapy may accurately represent how highly emotions are compromised.

It appears that language and proficiency can express and are attached to two different emotional meanings and two different cognitive sets in therapy. Although both languages have

similar conceptualization of words, they are emotionally charged with different meanings. Each language has been learned in different developmental times, contexts and cultures and, as such, has different classification and association of experiences. Given what the researches above have identified that each language have two different emotional and cognitive meanings, it becomes clear that each language is essentially connected with a person's culture and has a unique representation and mediation process with a person's unique verbal, phonemic and semantic components (Vygotsky, 1962). Language choice can also represent an attempt to reconnect to the emotional content, or can also occur as a coping mechanism to avoid or minimize the overwhelming and painful material when in therapy. An LEP individual may reveal only a few components of their personality based on reactions to the immigration process and anticipations about the clinician and therapy process, which has a direct effect on empathy, trust, feeling understood, alliance and so on.

### **Summary and Study Goal**

The purpose of the study is to understand the experiences of LEP clients with regard to their emotional expression and relationship development in therapy. Research has shown that language is fundamental in shaping our communication and self-perception and also regulates our experiences. Scholars have suggested that for individuals who learn a second language in adulthood, the second language may not have these functions. Thus, when these individuals enter into therapy, their emotional processes and self-understanding may not work as effectively if that therapy is in their second language. However, other scholars suggest that in therapy, a second language can be used adaptively, given the individual's current experience in the world, as well as defensively to protect the client from trauma and anxiety. In this context, language choice is an important source of information for the clinician. However, most of what most of what is

known about the experiences of LEP clients with regard to emotional expression and therapy relationship development is based on theory. The purpose of the current study is to learn from clients directly about their experiences with regard to these two areas.

For the purpose of this study, I am exploring the patterns of emotional expression and therapy relationship issues with attention to linguistic shifting with LEP individuals who have experienced therapy in English with monolingual clinicians and who did not have the choice of language in therapy. If bilingual LEP clients cannot express themselves in therapy, clients may live and experience more in the context of their second self, and the effectiveness of the therapy at that point is questionable. It may help to establish better understanding, to provide more accurate assessments and cultural elucidations of mental health illness and treatment, and to communicate more easily with clients and their family members. The literature reviewed above highlights several theories about how LEP individuals may engage in and experience treatment and the reasons for these patterns of engagement. However, there are no studies that ask LEP individuals about their experiences directly. The proposed study aims to do just that, and to focus on their experiences associated with emotional expression and the therapy relationship.

While this study is primarily exploratory in nature, there are a few expectations regarding participant responses due to the theories reviewed. If consistent with the literature, LEP clients will feel that they can communicate their emotions during therapy more easily when expressing in their mother tongue. Themes to explore in the qualitative responses may include: easier access to emotional content, feeling more authentic, and using less energy to narrate and translate experience, as well as themes that are yet to be identified. If consistent with the literature, LEP clients also will describe feeling misunderstood by their monolingual (English speaking)

clinician due to language and cultural differences. Themes to explore in responses include issues of trust, relational authenticity, and a mutual understanding of presenting issues.

### **Research Questions**

What is unique about therapy processes for LEP clients who have learned English as adults? Specifically, how do clients feel about their ability to express their emotions? How does emotional expression connect to the therapy relationship?

## **CHAPTER III**

### **Methodology**

Language is fundamental in shaping our self and our world. Individuals learn through their caregivers how to understand themselves and how to relate with others. One's mother tongue shapes our early developmental experiences, early memories, and the how we regulate our emotions. For individuals who learn English as adults and immigrate to the United States, a new language represents a new self in a new world. This means that individuals with Limited English Proficiency (LEP) may express oneself in two languages with similar words and concepts, but they may evoke emotionally different meanings and experiences of self.

Each linguistic self is learned in a different context and time, allowing the individual to have two similar narratives with different symbolic codes to express the same experience. Scholars have suggested that for individuals who learn a second language in adulthood, the second language in therapy can be used both adaptively, given the individual's current experience in the world, or defensively to protect herself from trauma and anxiety. It is important to take in account that the second language may be emotionally related to a process of loss and grief as an aspect of the immigration process. Furthermore, language fluency may also have implications in therapy in terms of misunderstandings in the session or implications in the relationship with the clinician.

Despite these theories, the majority of the literature on bilingual therapy lacks the perspective of LEP individuals. As such, a phenomenological-oriented, mixed method approach

was used in this pilot study to allow the experiences of LEP individuals to be understood in a broad and rich form, and for basic trends to emerge. This study was specifically designed to understand the experiences of LEP clients with regard to their emotional expression and relationship development in therapy when speaking in English. The study asked LEP clients to describe their emotions processes, self-understanding, and their relationship with their clinician.

The goal of the study was for LEP individuals to clarify whether using a second language in therapy accurately represents emotional and personal experiences, or if using a second language inhibits the true self and therefore inhibits emotional expression and the development of a strong therapy relationship. The study questions were as follows: What is unique about therapy processes for LEP clients who have learned English as adults? Specifically, how do clients feel about their ability to express their emotions? How does emotional expression connect to the therapy relationship?

Based on the literature reviewed, themes in the quantitative and qualitative responses may include: access to emotional content, authenticity (true self), and emotional expression narrating and translating experiences. Additional themes may include feeling misunderstood by a clinician due to language and cultural difference, issues of trust, relational authenticity, and mutual understanding of presenting issues.

### **Sample**

Approval for this research was obtained from the Smith College School for Social Work Human Subjects Review Committee (see Appendix A: HSR authorization letter). LEP individuals were surveyed via an online survey until the researchers identified an acceptable saturation point. Non-probability, purposive, and snowball sampling were used in order to obtain an appropriate sample of participants. Participants self-selected and recruitment efforts focused

on public spaces (both physical and virtual) where LEP individuals gather and communicate (see Appendix B through D) Eligible individuals were required to have (a) learned and spoken their mother tongue (not English) during childhood and adolescence; (b) learned English as a second language as an adult (over 20 years old); (c) immigrated to the United States as an adult; (d) lived in the US for at least three years; (e) had current or past experience in therapy speaking English. The researcher intended to obtain a racially and ethnically diverse sample, as well as a variety of primary languages (see Appendix E: Screening Page).

A total of 33 respondents accessed the online survey, 20 respondents met exclusion criteria and were redirected to the disqualification Page (see Appendix F: Disqualification Page). 13 respondents (four men and nine women) met inclusion criteria and after establishing eligibility, they verified their agreement with the informed consent in order to complete the survey (see Appendix G: Informed consent). All participants were encouraged to print a copy of the referral resources (see Appendix H: Referral Resources) and the survey was administered through SurveyMonkey to guarantee anonymity. The participants' ages were between 28 to 50 years old with an average age of 37 years and their countries of origin included nine individuals from Central and South America (Ecuador, Mexico, Bolivia, Argentina and Colombia), three from Europe (Portugal, Spain and Italy) and one from Eastern Europe (Jordan).

Native languages include Spanish, Portuguese, Arabic, and Italian, and participants learned English at the time of immigration, which ranged from 22-32 years old (mean = 27 years). On average, participants resided in the United States for 10 years and spent between 4 to 25 years in the United States. Five participants (4 female and 1 male) were currently in therapy for an average of 6 months, and the remainder of participants had past therapy experiences, which ranged from six months to two years.



## **Measures**

The first part of the survey included demographic questions. Participants were asked about their gender, age, country of origin, native language, race, and age when they learned English. Participants also were asked about age of immigration, years in the US, if they are currently in therapy, and if so, for how long, reason for therapy, or reason for termination.

The second part of the survey presented 21 quantitative and open-ended questions about their experience of emotions in therapy and therapy relationship. The quantitative items utilized likert scale questions to explore expression of emotions and feelings, satisfaction with the therapy and clinician, feeling understood, and experiencing trust. The open-ended questions explored how participant felt about expressing their emotions in English versus their mother tongue, the role of language difference between participant and clinician, feeling understood by the clinician, and preferred language to use in therapy. Finally, questions about expression of feelings, expression of thoughts, and expression of true self, were administered using checklist questions (see Appendix I: Survey).

## **Data analysis**

Participants were able to access online surveys until the saturation point was reached—the point when a new interview seemed to yield little additional information. Given the exploratory, pilot nature of the study and limited variability in the data, there is limited rigor in terms of broader theme analysis. However, several steps were taken to ensure reliability and validity.

First, peer debriefing was used to ensure that the themes that were identified were logical given the data. Peer debriefing occurred through utilizing the thesis advisor as a fellow researcher who also explored her own responses to the raw data and I used these responses to

support mine. Next, we discussed the identified themes and reflected on biases given previous expectations. Together, we came to a consensus about how to understand data.

Second, negative case analysis was used to look for participants (n=1) whose story varied from the themes identified, and we attempted to understand why their data varied.

Lastly, the following audit trail is offered to provide a final contribution towards reliability and validity. Analysis of the mixed-method survey consisted of four parts. First, demographic data was analyzed to provide an overall sense of the participant pool. Second, qualitative analysis of open-ended responses occurred and themes were coded for each question. Third, visual interpretation of likert scale and checklist questions occurred. Fourth, frequency counts and means interpretations of likert scale and checklist questions were calculated. Checklist and qualitative questions were used to determine the relationships between language, thoughts, and emotions. Checklist and qualitative questions were also used to explore expression of self, expression of feelings, and conformity and/or trust in therapy.

## **CHAPTER IV**

### **Findings**

Individuals with Limited English Proficiency (LEP) face several challenges when entering therapy. This exploratory pilot study focused on the role of language in emotional expression and the development of the therapeutic relationship. This is important because LEP individuals who have experienced recent immigration and learned English as adults have special needs when presenting to treatment, and these are often not fully understood. However, clinicians need to be prepared and fully understand the role of language in shaping how somebody engages in therapy.

#### **Treatment Seeking and Ending**

First, participants were asked why they sought treatment and why they ended it (if they had done so). Participants reported that they sought treatment for issues related to mood (anxiety, OCD, overwhelming feelings, grief), adjustment issues (reactions to US culture, academic withdrawal) and relationship issues (domestic violence, marriage difficulties and divorce). Six participants (4 females and 2 males) also shared that they ended treatment as a pre-planned termination and seven participants (5 females and 2 males) shared that they ended treatment due to conflicts with the clinician, including disagreement with treatment plan and cultural misunderstandings.

## **Emotional Expression**

**Translation.** In terms of translating feelings, the majority of participants (69%) expressed that the words they find in English did not translate to the exact meaning they want to communicate. Of the remaining participants, two individuals expressed that they usually did not find words to translate their feelings in therapy; and one individual stated that he never found words to translate his exact feelings. Only one participant did not have any problem translating her words across languages, but did note that these translations had a different “intensity.” Issues such as finding words that precisely represent an individual’s feeling or finding appropriate phrases for the situation were the most common concerns.

**Comfort with English.** Qualitative data showed that subjects, on average, felt comfortable using English in therapy (rating a 4 on a 5 point scale - checklist), but expressed a preference to use their mother tongue in therapy if they had the option.

**Expression.** Qualitative data highlighted that all participants acknowledged a direct connection between language and emotions. All individuals reported a difference between their connection to emotions when using mother tongue and the translation in English. In fact, all subjects reported that English did not allow for full expression of their emotions when talking about childhood, conflict with parents, emotional pain, and frustration. All participants stated that they preferred to talk about their most difficult experiences in their mother tongue. When they used their mother tongue, participants felt the most satisfied about their connection to their emotions and to the clinician.

Only a small subset felt entitled to use their mother tongue as needed to engage in emotional expression. Three participants stated that they expressed their feelings in therapy in their mother tongue, as they did not find the appropriate translation. They also noticed that their

mother tongue “came first” when they felt upset and/or emotional, and that translations would not have expressed the intended meaning. Across the board, participants felt that issues related to translation (including sense of humor, customs, and cultural slangs) inhibited the communication and expression of their true feelings and experiences.

Quantitative data highlighted that expression of emotions and expressions of thoughts are different processes. Compared to the above findings, the majority of people (53%) expressed that it was easy to express their thoughts in English, but that it was hard and difficult to express their emotions in English. However, some (38%) expressed difficulty in expressing both thoughts and emotions during therapy, and just one participant (7%) expressed no difficulty expressing thought and emotions in therapy.

### **Therapy Relationship**

**Issues related to treatment satisfaction.** Quantitative data suggested that 50% of the participants were satisfied overall with the treatment. The majority (46.2%) rated their satisfaction at a 4 on a 5-point scale, and the rest of the participants indicated either feeling neutral or very satisfied. Only one participant felt very unsatisfied with their treatment.

Quantitative data also examined satisfaction with treatment in terms of personal capacity for expression. Again the majority (61.5%) was satisfied, and the remainder was either neutral or very satisfied; no participants reported feeling completely dissatisfied.

**Issues related to clinician satisfaction and trust.** Quantitative data suggested that the majority of the sample (53%) indicated feeling satisfied with their clinician, although a small group felt dissatisfied (23%). About 15% felt neutral about their clinician, while only 7% were very satisfied.

Despite general satisfaction, all participants reported that language differences made the therapy relationship difficult. Eighty-five percent reported that speaking in English as a second language interfered with the development of a strong relationship with the clinician. More than two-thirds of the group (69%) stated that they would have more trust in a clinician who shares their same mother tongue, while only one participant felt deeply understood by and able to trust in a monolingual English clinician. Qualitative data also showed that the use of English language affected trust in therapy. The issues highlighted by participants included constant clarification when describing situation or emotions and cultural differences in terms of interpersonal behaviors and expectations of each other.

**Feeling understood and the true self.** Quantitative data was used to explore how participants felt about how their clinician understood the presenting issues. Overall, most of the participants felt that the clinician understood their presenting issue. The majority (62%) “Agreed” that they felt understood, while a slightly smaller group (23%) “Strongly agreed.” Only one participant reported feeling neutral, and one individual felt that the clinician did not understand presenting concerns at all.

Although most of the participants felt that the clinician understood the presenting issue, they did not feel that they could fully be themselves in therapy, in part because they could not express the exact meaning of their feelings. All participants reported that they did not feel like their “true self” when speaking English in therapy. Most of the participants reported that language interferes with feeling like their true self could be understood in depth by the clinician. Qualitative data highlighted several themes that are reflected in the quantitative data described above. Overall, subjects reported feeling that their clinician understood most symptoms of

anxiety and everyday challenges. However, participants consistently felt that cultural understanding was a point of difficulty, and that their emotions were not very well understood.

### **Beliefs about Mother Tongue**

Qualitative data highlighted several important themes about participants' beliefs surrounding the use of mother tongue and the therapy process. It is important to note that all subjects would have preferred the use of their mother tongue if they had been able to make that choice.

First, participants expressed that the clinician could not provide the same level of validation and/or soothing in comparison to when a second language is used. They noted that speaking a second language created a relational and technical barrier when expressing content related to humor, culture, customs, slang, and nuanced emotional expression.

Second, participants reported a preference to speak the mother tongue with regard to particular issues, including culture, early development, parental relationships, and experiences associated with trauma. Subjects believed that the use of the mother tongue in these contexts would be more meaningful. They also felt that emotions and culture might be expressed or understood in a better way when speaking in the mother tongue. Overall, they felt that the use of their mother tongue would allow for a much stronger connection to their feelings and to their clinician.

Third, participants stated that they could express the cognitive aspects of their ideas but that the words did not express the complexity of their feelings. It is important to note that one participant felt that her emotional expression was acceptable in therapy. However, all participants felt that they had great difficulty accessing their developmental experiences when

using English, and reported that childhood experiences and memories were best expressed in their mother tongue.



## **CHAPTER V**

### **Discussion**

Individuals with Limited English Proficiency (LEP) face several challenges when entering therapy because language can affect emotional expression, the therapeutic relationship and sense of self. The current exploratory study was created to answer and reflect about the following question: What is unique about therapy processes for LEP clients who have learned English as adults? Specifically, how do clinicians feel about their ability to express their emotions? How does emotional expression connect to the therapy relationship?

#### **Emotional Expression**

The findings of this study are largely congruent with the reviewed literature and suggest that expectations about therapy in the mother tongue are substantially different to those about therapy in English. Participants believed that the use of the mother tongue in therapy would allow for greater connection to and expression of emotions, and therefore would allow for a stronger sense of self and more satisfaction with therapy and the clinician. The study results broadly suggest that the use of mother tongue allows for expression of emotions and thoughts with a meaning and intensity that is impossible to translate to English. Using one's mother tongue in therapy also allows for the expression of cultural phrases associated with humor, slang, customs, and developmental history. The study results also suggest that the difficulty translating exact emotions and culturally specific phrases has a strong negative impact on the therapeutic relationship and treatment goals.

Two important and unique contributions were made to the literature regarding emotional expression for LEP individuals. First, language proficiency may have a particularly critical role in how we understand splitting in the context of emotional expression. Specifically, language proficiency and word order may affect emotional expression because higher levels of proficiency are related to more emotionally-shaped association. As explored by Lambert (1956) in his study on language associations and emotional responses at multiple stages of language proficiency, higher proficiency is associated with more emotionally meaningful content. This finding seems to suggest that LEP individuals may not be as able to communicate “meaningful” emotions or “provocative” responses in a second language. In this case individuals may not choose English as a defense function (including linguistic shifting and splitting) to communicate deeper experiences, and that this defensive process may happen elsewhere.

Second, the findings of this study suggest that LEP individuals consistently utilize linguistic shifting to maximize their psychologically adaptive functioning (rather than a defense mechanic or avoidance, as discussed above). Participants reported that the use of linguistic shifting was a way to accurately express the original emotions and/or thoughts that may not have a literal translation. Across the board, participants expressed a belief that they would be best served by a clinician who could speak to them in their mother tongue. The research conducted by Javier (1989) supports this finding. Javier’s work suggested that linguistic shifting was adaptive because it allowed for a fully and proper expression of emotion and a strong connection with oneself and one’s culture. It appears that speaking in one’s mother tongue allows for richer, nuanced, deeply symbolized, and more directly connected experiences of one’s true inner emotions. With this understanding, the results in this study suggest that English cannot fully

represent LEP individuals' emotions when they talk about their childhood, conflict with their parents, pain, and/or frustration.

This study is also consistent with theory that suggests LEP individuals have a dual way to express emotion with two different but coexistent thinking processes, thought patterns, and rhetorical styles. This dual process also includes non-verbal communication, specifically the emotion expressed with gestures, eye contact, touch, and space among other manifestations. This finding from the current study corresponds to Pérez Foster's (1996) theory that LEP individuals have two sets of coding and decoding experiences and feelings, and two different experiences and understandings of the self that are constructed, organized, and experienced in each language. We see that each self-representation evokes a different culture, developmental and emotional experience, relational process, personal and social identity. As per Pérez Foster (1992), a bilingual LEP adult is forced to develop a new sense of self during the immigration process in order to adapt to the new environment, which appears to be consistent with the current study population.

Finally, it appears that issues of translation emerge as a key component of emotional expressions. Participants noted in queries about emotional expression, trust, and therapy preferences that difficulty finding words that translated the exact meaning of what they were thinking and feeling was a consistent difficulty. Furthermore, participants noted that the translation often did not even exist in the English language, further inhibiting their emotional expression and their capacity to express their true self and be known by their clinician more fully.

As we review the findings from the emotional expression aspect of this study, it appears that LEP individuals are by default at a linguistic disadvantage when entering therapy in English

because they are not proficient and are limited in their ability to accurately express their thoughts and emotions. It is likely that therapy for LEP individuals that is conducted in English is going to involve categorically different ego functions and defenses than therapy in an individual's mother tongue. Discussed further below, utilizing one's mother tongue also offers different relational processes within the therapy relationship because enactments in therapy may be lost as a result of complications that require clarification, translation, or cultural context explanations.

### **Therapy Relationship**

Difficulties with emotional expression, language proficiency, and dual self significantly impact the therapy relationship. It seems challenging for a monolingual English clinician working with a client with LEP to fully understand what the client said if the client uses the mother tongue. The clinician would have difficulty interpreting that content in context. This process may affect the therapy negatively because LEP individuals frequently need to explain or translate their feelings. The constant use of clarification can make the client feel misunderstood, and therefore may also affect the development of trust in the therapeutic relationship. This finding is consistent with Sprowls' (2002) scholarship that argues that the lack of translation for certain ideas and the increased effort needed to convey these ideas in another language is influenced by cross-cultural difficulties and can increase frustration for both the client and the clinician. It may be that the use of English in LEP individuals' therapy impairs full expression of emotions and thoughts necessary to create the same effectiveness that a therapy in the mother tongue would provide by default.

Linguistic differences between the client and clinician can also shape the therapeutic communication in terms of how well the clinician is able to understand the client's background. Mother tongue not only represents linguistic communication but also culture and customs.

Therefore, language also has an important effect on how the clinician understands the client on the most fundamental level. In the current study, half of the participants indicated feeling satisfied with their clinician, suggesting that using one's mother tongue in therapy empowers the client to feel more connected and less secluded. However, despite having difficulty expressing their emotions, the individuals in this study expressed feeling quite satisfied with the therapy in terms of expression of their thoughts.

Since language difference has shown to affect satisfaction with the clinician and the development of trust, it was important to better understand what shaped this finding. It appears that feeling understood by the clinician and feeling like that the clinician had an ability to connect to the client's true self were important factors. Most of the participants felt that the clinician understood the reason why they went to therapy, despite the fact that the participants did not feel that they could be fully themselves in therapy due to limited expressive capacity. While participants felt like their symptoms and everyday challenges were understood, they appeared to experience a lack of cultural understanding from the clinician that interfered with the participant's full sense of self, including slang, sense of humor and cultural expressions. In this context, then, we can understand how deeper emotions, which we know are tied to early experiences, are not only less accessible to the client, but also to the clinician. This clearly has a direct effect on the therapy relationship and is consistent with Javier's (1989) work that also suggested that LEP clients might experience alienation with the clinician if they are not able to feel understood or able to communicate their feelings associated with the original self and the adaptive self.

In addition, this study's results suggest that monolingual English clinicians cannot provide a satisfactory level of validation and/or soothing when the client's second language is

used. This may be especially true in regards to issues of culture, early development, parents, and trauma. In these cases, the participants felt misunderstood and detached from their own sense of authenticity. In contrast, when using their mother tongue, the participants felt that they could connect much better to their feelings and to the clinician.

The constant dual experience of self for LEP individuals in therapy is critical because it can explain why the individual expresses emotions and thoughts differently in each language. As a result of this nuanced understanding, clinicians can refrain from interpreting this behavior diagnostically. This study as a whole then suggests that an LEP individual may present to treatment with dual personalities, coping strategies, and capacities to access to personal history; and this duality can be explained linguistically rather than diagnostically because each linguistic representation of self manifests differently.

### **Concluding thoughts**

It is important to understand the difference between LEP and fully bilingual individuals in order to avoid misunderstanding in treatment. Fully bilingual individuals can communicate in both languages completely and therefore are likely to use splitting and shifting as adaptive or maladaptive mechanisms to manage more intense emotions and aspects of personal history. For LEP individuals, however, the current research shows that participants actually preferred to use their mother tongue to express their emotional experiences, and that this preference is related to issues of proficiency instead of emotional defensiveness. Linguistic shifts to native language in an LEP individual conducting therapy in English are not representations of defense mechanisms but instead, are a representation of or connectivity with the core self when the individual wants to express their thoughts and emotions.

This has strong implications for the therapy relationship. Clinicians of LEP individuals who cannot represent their true self when doing therapy in English will lack a full understanding of the client's identity, and the therapy and therapeutic relationship will likely be negatively impacted unless particular adaptations are made to the therapy process. These difficulties with being fully known, particularly with regard to issues as immigration, culture, risk factors, and acculturation may confuse diagnostic processes or lead to an interpretation that a defense mechanisms is being used in therapy. Is important for the clinician to be open cross culturally to understanding the client's different types of communication that are related to language and culture.

Furthermore, it is important to recognize that LEP individuals usually do not choose to have therapy in English and are not aware that they always express their true self better with their mother tongue as opposed to English, the language which was learned as an adult, usually in relation to challenging immigration process. As such, the mother tongue is by default connected to LEP individual's unconscious and developmental processes and linguistic shifting are the remarkable manifestations and attempts to connect to their real self rather than self defense mechanisms. If the English-speaking clinician does not understand this, the clinician can misread the client's needs and unconscious communications when the client makes attempts to reconnect to their mother tongue during the session in the service of authenticity and emotional expression.

This current study suggests that it is preferable to offer therapy to LEP individuals in their mother tongue or by a clinician who is bilingual, although they may not share the same non-English language. This makes it so that the clinician not only might share a similar or the same language, but the clinician will also have a clearer understanding of the client's cultural

background and linguistic process. This would likely be associated with a greater understanding about the role of power dynamic in therapy. Although not discussed in this paper, is important to take into account the role of racism and ethnicity within the therapeutic relationship and how assumptions may also play a role between the clinician and the LEP client. Through understanding the associated language issues, clinicians can gain an appreciation for the fact that LEP individuals did not grow up in this country and therefore their personality and development were not shaped within the US's concepts of racism and power dynamics.

### **Limitations**

There are several limitations in the current study. First, this sample size is small due to the exploratory nature of the study design. A larger and more diverse sample would bring greater clarity to the power of the current findings and possibly provide further insights to LEP clients in therapy. It is likely that a larger sample would contain more diversity of responses and provide clarity around the experience of LEP individuals who were satisfied with their capacity for emotional expression. A replication of this study with a larger sample of LEP individuals is suggested.

Second, it is unclear if the sample population is representative of the larger population of LEP speaking individuals. Since most of the sample was Spanish speakers, it is also unclear if the experiences of LEP Spanish speakers are similar to those who speak other languages. For example, the processes that are reviewed for LEP Spanish speakers may not exist in the same way for LEP Arabic speakers.

Third, the current study did not assess if clinicians every addressed the language barriers directly or if there as a collaborative process of working with issues of proficiency.



Conversations such as this may have a positive impact on client's experiences of therapy generally and of their clinician's capacity to understand them.

Finally, the current study did not directly assess participants' levels of proficiency; instead, this information emerged in the qualitative data. It is likely that the individual who did not have difficulties expressing emotion in therapy had a significantly higher level of proficiency than the rest of the sample. It is important to note that this individual still expressed a preference for therapy in the mother tongue. As such, it is unclear what the exact relationship is between proficiency, emotional expression, and the therapy relationship. It is recommended that future studies directly assess proficiency in order to provide support for the conclusions made in the current paper.

### **Future Directions**

The current study shows that language proficiency is necessary to have more clarity and communication of emotions and to express one's true self in treatment. However, research has also shown (Gutfreund, 1990) that some languages have higher emotional expressivity than others. Future research with LEP and bilingual individuals must consider this to best understand how language shapes the therapy process and the therapy relationship.

Two additional areas of research are recommended based on the current study. First, further research is needed to fully address the difference between fully bilingual and LEP individuals. These two groups of individuals share similar language challenges but speak with very different levels of proficiency, which will likely change the meaning and use of splitting and shifting in therapy. It is recommended that a comparative study be completed to look at these differences directly.

Second, further research is needed to explore the client's experience when the clinician shares the same mother tongue and similar culture. For example, Alonzo (2009) suggested that sharing the mother tongue between clinician and client builds trust, connection, and treatment engagement. If the client and clinician have similar cultural backgrounds, the risk of misunderstanding may decrease, especially in regards to the client's emotional expression, motivation for language shifting, and culturally informed speech and behavior. In this case, the clinician will not only understand the client through their shared cultural background, but also through an understanding of thoughts and feelings that can only truly be expressed using their mother tongue.

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## Appendix A: HSR authorization Letter



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**School for Social Work**  
Smith College  
Northampton, Massachusetts 01063  
T (413) 585-7950 F (413) 585-7994

February 2, 2015

Maria Plazas

Dear Maria,

You did a very nice job on your revisions. Your project is now approved by the Human Subjects Review Committee.

*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.

Congratulations and our best wishes on your interesting study.

Sincerely,

A handwritten signature in black ink, appearing to read 'Elaine Kersten'.

Elaine Kersten, Ed.D.  
Co-Chair, Human Subjects Review Committee

CC: Mamta Dadlani, Research Advisor

## Appendix B: Recruitment Email

Dear Participant,

Thank you for your time and consideration of my study. My name is Maria Plazas, and I am an MSW candidate in Clinical Social Work at Smith College for Social Work. I am currently conducting research for my MSW thesis, and I want to explore the experiences of individuals who have Limited English Proficiency and have also been in therapy. I am specifically interested in learning more about the advantages and disadvantages of receiving therapy in a non-native language and how it affects the expression of feelings and thoughts. The Human Subjects Review Committee at Smith has approved this research.

In order to participate you must have

- Learned and spoken their mother tongue (not English) during childhood and adolescence
- Learned English as a Second Language as an Adult (20 year old or older)
- Immigrated to the United States as an adult (20 year old or older)
- Lived in the country for at least three years
- Had current or past experience in therapy speaking English

To participate, you will complete an anonymous survey online that will ask you to write about your experiences in therapy. This will require approximately 20-25 minutes of your time.

Your participation will help to increase knowledge and awareness about the importance of mother tongue in therapy when discussing emotions and feeling comfortable in therapy. This study may help counselors improve counseling services and develop therapy programs that meet the language needs of minority and multicultural individuals.

If you are willing to complete this brief survey, please click on the following link:

<https://www.surveymonkey.com/s/mplazas>

If you have any questions or concerns about this study, please do not hesitate to contact me at [mplazas@smith.edu](mailto:mplazas@smith.edu). You may also contact the Chair of the Smith College School for Social Work Human Subjects Review Committee at (413) 585-7974.

Thank you very much for your time and help.

Best wishes.

**Maria Plazas**

M.S.W. Candidate, Smith College School for Social Work



## Appendix C: Flyer

# **BILINGUAL CLIENTS WHO LEARNED ENGLISH AS A SECOND LANGUAGE**

are needed to participate in a **study examining** the importance of mother tongue in therapy.

I am an MSW candidate in Clinical Social Work at Smith College for Social Work. I am currently conducting research for my thesis and I am interested in learning more about the advantages and disadvantages of receiving therapy in a non-native language and how it affects the expression of feelings and thoughts. Participation is anonymous, has been approved by the Human Subjects Review Committee at Smith, and will require approximately 20-25 minutes to answer a series of open ended questions.

## **SUBJECTS MUST MEET THE FOLLOWING CRITERIA:**

1. Learned English as a Second Language after the age of 20 years old
2. Immigrated to the United States after 20 years old and lived in the US for at least for three years;
3. Have current or past experience with therapy in English.

If you are willing to complete this brief survey, please click on the following link: <https://www.surveymonkey.com/s/mplazas>

If you have any questions please contact Maria Plazas [mplazas@smith.edu](mailto:mplazas@smith.edu)

THANK YOU FOR YOUR HELP!

## Appendix D: Recruitment - Facebook

**Facebook Friends!** Speak up and share your experiences valuable knowledge!

1. Did you learn English as a Second Language as an Adult (20 year old or older)?
2. Did you immigrate to the United States as an adult (20 year old or older)
3. Have you lived in the United States at least for three years?
4. Do you have current or past experience with therapy in English?

If so, you could help me out with my Master's Thesis. It is a brief open-ended questionnaire that looks at the importance of mother tongue in therapy. The survey is anonymous, and should take 20-25 minutes. Please take a look at the study for more information and please message me if you have any questions! Your feedback is important!

If you are willing to complete this brief survey, please click on the following link:

<https://www.surveymonkey.com/s/mplazas>

## Appendix E: Screening Page

In order to participate in this study, you must meet the following criteria:

- 1- Learned English as a Second Language after the age of 20 years old
- 2- Immigrated to the United States after 20 years old and lived in the US for at least for three years;
- 3- Have current or past experience with therapy in English.

“I agree that I meet ALL of these criteria” (checkbox)

“I meet SOME or NONE of these criteria.” (checkbox)

\* If participants click on the 2<sup>nd</sup> button, they will be directed to the Disqualification page.

## **Appendix F: Disqualification Page**

Thank you for your time and interest in this study. Unfortunately, your answers to the previous question indicate you are not eligible to participate in this study.

However, if you know others who may be interested in participating and may meet the study requirements, please share this study with them on Facebook or by forwarding the survey link <https://www.surveymonkey.com/s/mplazas>

To exit, simply close the browser window.

## Appendix G: Informed Consent

### Consent to Participate in a Research Study Smith College School for Social Work • Northampton, MA

.....

**Title of Study: IMPLICATIONS OF ENGLISH LANGUAGE IN THERAPY FOR LIMITED ENGLISH PROFICIENCY (LEP) CLIENTS.**

**Investigator:**

**Maria Plazas**

M.S.W. A15 Candidate, Smith College School for Social Work

[mplazas@smith.edu](mailto:mplazas@smith.edu)

.....

#### **Introduction**

- You are being asked to be in a research study examining the implications in therapy for individuals that are non-native speakers and who have learned English as an adult. I am specifically interested in learning more about the advantages and disadvantages of receiving therapy in a non-native language and how it affects the expression of feelings and thoughts.
- You were selected as a possible participant because you have learned English as a Second Language as an Adult (20 years old or older); immigrated to the United States as an adult (20 year old or older); lived in the United States at least for three years; and have current or past experience in therapy in English.
- Please read this form and ask any questions that you may have before agreeing to be in the study.

#### **Purpose of Study**

- The purpose of the study is to understand the experiences of LEP (Limited English Proficiency) clients with regard to their emotional expression and relationship development in therapy.
- This study is being conducted as a research requirement for my master's in social work degree.
- Ultimately, this research may be published or presented at professional conferences. No identifying data will be presented.

#### **Description of the Study Procedures**

If you agree to be in this study, you will be asked to do the following things:

- To complete an anonymous online survey that will ask you to write about your experiences in therapy. The questionnaire will ask demographic information, and multiple choice & open-ended questions about your experiences in therapy using the English language. This will require approximately 20-25 minutes of your time.
- To print a copy of this consent and the referral resources list for your records.

#### **Risks/Discomforts of Being in this Study**

- The study has the following risk. The questions may cause emotional discomfort and other strong feelings. You may feel distressed or upset during or after completing the survey.
- A referral list for support post participation is provided. Please print this list to identify sources of support.

#### **Benefits of Being in the Study**

- The benefits of participation are:
  - To have the opportunity to gain insight about the benefits /challenges when having a therapy only in English.
  - To have the opportunity to express this benefits/challenges that are important for you.

- The benefits to social work/society include:
  - Increased knowledge and awareness about the importance of mother tongue in therapy when discussing emotions and feeling comfortable.
  - Possible improvements to counseling services and the development of therapy programs that meet the language needs of minority and multicultural individuals.

### **Confidentiality**

- This study is anonymous. I will not be collecting or retaining any information about your identity. Your participation will be kept confidential and your anonymous responses will be available only to my research advisor and me. Once you have submitted your answers, it will not be possible to withdraw from the study, since it will be impossible for me to identify your survey responses from the others that have participated in the study. The survey software does not collect names, email addresses, IP addresses, or any other identifying information.
- All the data retrieved from SurveyMonkey will be stored in a secure location for three years according to federal regulations. In the event that materials are needed beyond this period, they will be kept secured until no longer needed, and then destroyed. All electronically stored data will be password protected during the storage period. We will not include any information in any report we may publish that would make it possible to identify you.

### **Payments/gift**

- You will not receive any financial payment for your participation.

### **Right to Refuse or Withdraw**

- The decision to participate in this study is entirely up to you. You may refuse to take part in the study at any time (up to the date noted below) without affecting your relationship with the researchers of this study or Smith College. Your decision to refuse will not result in any loss of benefits (including access to services) to which you are otherwise entitled. You have the right not to answer any single question or to discontinue taking the survey at anytime.

### **Right to Ask Questions and Report Concerns**

- You have the right to ask questions about this research study and to have those questions answered by me before, during or after the research. If you have any further questions about the study, contact me, Maria Plazas at [mplazas@smith.edu](mailto:mplazas@smith.edu) at any time. If you would like a summary of the study results, you can email me directly to indicate this desire and a summary will be sent to you once the study is completed. If you have any other concerns about your rights as a research participant, or if you have any problems as a result of your participation, you may contact the Chair of the Smith College School for Social Work Human Subjects Committee at (413) 585-7974.

### **Consent**

- Your consent indicates that you have decided to volunteer as a research participant for this study, and that you have read and understood the information provided above. Please print this consent for your records. On the next page, you will be given a list of referrals and access information if you experience emotional issues related to your participation in this study.

Thank you for your interest in the study.

Sincerely,

Maria Plazas  
MSW Candidate

\*By checking the box below that says "I Agree", you are indicating that you have decided to volunteer as a research participant for this study; that you have read and understood the information provided above; and that you understand that you will be directed to the referral list and the beginning of the actual survey after.

\*Please print this consent for your records and click NEXT

I Agree (checkbox)

I disagree (checkbox)

## Appendix H: Referral Resources

**If you are an Undergraduate or graduate student please contact your local:**

College or University Counseling Services  
College or University Student Health Care Center

### **Other referral resources:**

National Suicide Hotlines: 800-SUICIDE (784 2433)

National Suicide Prevention Lifeline 1-800-273-TALK (8255)

National Association of Anorexia Nervosa & Associated Disorders (ANAD): 847-831-3438 (long distance)

National Mental Health Association: 800-969-6642

National Alliance on Mental Illness NAMI 1-800-950-NAMI (6264)

Grief Recovery Helpline: 800-445-4808

The Alcohol & Drug Addiction Resource Center: 800-390-4056

National Drug Information Treatment and Referral Hotline: 800-662-HELP (4357)

Alcohol Abuse and Crisis Intervention: 800-234-0246

Alcohol and Drug Abuse Helpline and Treatment: 800-234-0420

Alcohol Hotline Support & Information: 800-331-2900

Drug & Alcohol Treatment Hotline: 800-662-HELP

National Sexual Assault Hotline at 1-800-656-4673 or visit [www.rainn.org](http://www.rainn.org)

National AIDS Hotline: 800-342-AIDS (2437)

National Sexually Transmitted Disease Hotline: 800-227-8922

National Domestic Violence Hotline: 800-799-SAFE (7233), 800-787-3224 (TTY) 800-942-6908 (Spanish)

Domestic Violence Hotline: 800-829-1122, 800-799-7233

National Domestic Violence Hotline 1-800-799-SAFE (7233)

STAND Against Domestic Violence Crisis Hotline: 888-215-5555

SafeQuest Crisis Line: 866-487-7233 (4UR-SAFE)

Help Finding a Therapist 1-800-THERAPIST (1-800-843-7274)

**\*Please print or copy this list of referrals for your records and click NEXT.**



## Appendix I: Survey

**Please note:** Depending on the participant's answer to Demographic Question #8, the survey will either be presented in present tense or past tense using survey monkey's features. The survey below is written the in the present tense.

### Demographic Questions

Please answer the following questions about yourself:

- 1. What is your gender?**  
(Comment box)
- 2. How old are you?**  
(Comment box)
- 3. What country are you from?**  
(Comment box)
- 4. What is your native language / mother tongue?**  
(Comment box)
- 5. How would you describe your race?**  
(Comment box)
- 6. At what age did you learn English?**  
(Comment box)

### Part 2: Questions

- 6. At what age did you immigrate to the United States?**  
(Comment box)
- 7. How many years have you lived in the United States?**  
(Comment box)
- 8. Are you currently in therapy?**  
Yes/No  
**If yes, for how long have you been in therapy?**  
(Comment box)  
**If no, when were you last in therapy?**  
(Comment box)  
**If no, for how long were you in therapy?**  
(Comment box)
- 9. Briefly, describe why you decided to go to therapy.**  
(Comment box)
- 10. If applicable, please explain why you ended the therapy.**  
(Comment box)

**Next, you will find 21 questions. Eleven will ask you about your experience of emotions and ten about your relationship with your therapist. Some of these questions will ask you to explain your answers or will ask you to describe something. Please answer these write-in questions as best you can, but do not worry about providing every detail about your experience.**

**As you complete the survey, the tracking bar at the top of the page will show you how much of the survey you have completed. Please do your best to answer each question. Thank you for your time.**

## **EXPERIENCE OF EMOTIONS IN THERAPY**

**Please think about your ability to express your emotions in therapy**

**1. How satisfied are you with your therapy overall?**

1) very unsatisfied 2) unsatisfied 3) neutral 4) satisfied 5) very satisfied

**2. How satisfied are you with your ability to express your emotions in English?**

1) very unsatisfied 2) unsatisfied 3) neutral 4) satisfied 5) very satisfied

**Please explain:** (comment box)

**3. Describe a moment in therapy when you felt that the words you used in English were not representing your true feelings or experience**

(comment box)

**Imagine that you are in therapy and you have the opportunity to speak in either English or your mother tongue.**

**4. Please describe a moment when you would prefer to speak in English and NOT in your mother tongue**

(comment box)

**5. Please describe a moment in therapy when you would prefer to speak in your mother tongue.**

(comment box)

**6. When speaking English in therapy:**

(select one)

- It is easier to express my feelings
- It is easier to express my thoughts
- Both my feelings and thoughts are easy to express
- Both my feelings and thoughts are difficult to express

**7. Describe your ability to express your emotions in English**

(select one)

- I can express my emotions without a problem
- I usually do not find the words to translate my feeling
- I find words, but they do not translate to the exact meaning I want.
- I translate my feelings well but my therapist does not understand me.
- My feelings do not have a translation

**8. It is easier to use English to express myself in therapy when my concerns are related to:**

(select all that apply)

- my work/studies
- my culture/customs
- my childhood/adolescence
- my family and parents
- my friends
- my romantic relationships
- my sexuality
- my spirituality
- Other:(comment box)

**Below are some statements about what you might have experienced in therapy.**

**9. Please select any statements that feel true to you.**

- I can express my thoughts and feelings clearly but my experiences are emotionally difficult to talk about
- I can express my thoughts and feelings clearly but my therapist does not understand my English
- I can express my thoughts and feelings clearly but my therapist does not understand my Culture
- None of these statements are true for me

**10. Please select the statement that feels more accurate.**

- I prefer to talk about my most difficult experiences in my mother tongue.
- I prefer to talk about my most difficult experiences in English.

**11. Please select the statement that feels more accurate.**

- I do not feel like my true self when speaking English in therapy.
- I do not feel like my true self when speaking my mother tongue in therapy.

**THERAPY RELATIONSHIP**

**12. I am satisfied with my therapist**

- 1) Strongly disagree 2) Disagree 3) Neither disagree or agree 4) Agree 5) Strongly Agree  
Please explain:

**13. My therapist understands the reason I began therapy.**

- 1) Strongly disagree 2) Disagree 3) Neither disagree or agree 4) Agree 5) Strongly Agree

**14. The language differences between me and my therapist make therapy difficult.**

- 1) Strongly disagree 2) Disagree 3) Neither disagree or agree 4) Agree 5) Strongly Agree

Please explain:

**15. Speaking in English makes it harder for me to have a strong relationship with my therapist.**

- 1) Strongly disagree 2) Disagree 3) Neither disagree or agree 4) Agree 5) Strongly Agree  
Please explain:

**16. I feel understood by my therapist during my sessions.**

- 1) Strongly disagree 2) Disagree 3) Neither disagree or agree 4) Agree 5) Strongly Agree

**17. I feel misunderstood by my therapist during my sessions.**

- 1) Strongly disagree 2) Disagree 3) Neither disagree or agree 4) Agree 5) Strongly Agree

**18. Describe a moment when you felt misunderstood by your therapist due to the differences in language.**

(comment box)

**19. How did this experience shape your ability to trust your therapist.**

(comment box)

**20. My ability to trust my therapist would be stronger if I could speak in my mother tongue.**

1) Strongly disagree 2) Disagree 3) Neither disagree or agree 4) Agree 5) Strongly Agree

**21) Please share any additional thoughts you have about how your language abilities affect your relationship with your therapist.**

(comment box)