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Emily H. Avilés
Experiences of Multilingual Social
Workers: Trauma Therapy in
Spanish and English

ABSTRACT

This exploratory study examines the experiences of social workers engaging in multilingual—Spanish and English—therapy with individuals who speak both Spanish and English, identify as Latino/a, have a history of trauma, and identify as having a history (personal, familial) of immigration to the U.S. The study uses semi-structured interviews with 10 social workers to gather qualitative data about their experiences engaging in trauma therapy with individuals who identify as multilingual as well as Latino/a immigrants to the U.S. The project examines ways that multilingual clinicians process trauma with individuals in more than one language; paying attention to the ways clinicians think about language in therapy, what they observe about transference and countertransference, as well as conceptualize their use of self. An enhanced understanding of clinicians' experiences of engaging in trauma therapy in two languages may support the development of ethical and appropriate services to marginalized newcomers, as well as contribute more information about how to provide high quality services for multilingual individuals and immigrant populations.

EXPERIENCES OF MULTILINGUAL SOCIAL WORKERS: TRAUMA THERAPY IN
SPANISH AND ENGLISH

**EXPERIENCES OF MULTILINGUAL SOCIAL WORKERS: TRAUMA THERAPY IN
SPANISH AND ENGLISH**

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

EXPERIENCES OF MULTILINGUAL SOCIAL WORKERS: TRAUMA THERAPY IN SPANISH AND ENGLISH

ACKNOWLEDGMENTS

This thesis developed in the context of the ideas, curiosity, and care of many. I am grateful to the social workers that reflected upon and shared their experiences as multilingual therapists with me—a potentially vulnerable and invaluable endeavor. I offer special thanks to my thesis advisor, Jennifer Harrison, for her consistent guidance and encouragement. I also thank family and dear friends who steadily supported me throughout the process.

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CHAPTER I

Introduction

The purpose of this study is to gain insight into clinicians' experiences of multilingual therapy with individuals who have histories of trauma and immigration. The central question of this study is: What are the experiences of clinicians in processing trauma with Latino/a immigrant populations in the U.S. in two languages—Spanish and English? The study aims to gain a deeper understanding of what clinicians observe and the nuances of multilingual therapy with individuals who speak both Spanish and English, identify as Latino/a, have a history of trauma, and identify as having a history (personal, familial) of immigration to the U.S.

For the purposes of this study, *clinicians* will refer to licensed clinical social workers, and not psychologists, psychiatrists, nor other mental health workers. The term *treatment* refers to the assessment, development of a treatment plan, and implementation of a therapeutic treatment plan. *Immigrant populations* will be used to describe individuals who identify as having a history (personal or familial) of migration or immigration to the U.S. For the purposes of this study, the term *immigration* will include myriad paths of immigration, i.e. documented and undocumented immigration, refugees, and asylum seekers. The term *Latino/a* is used in the study to refer to one way—of many possible ways—that individuals of Latin American descent may choose to identify in a particular moment. *Multilingual* refers to individuals who speak more than one language (i.e. not monolingual), and is used in this study instead of the term “bilingual” because

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individuals may speak more than one language may also speak more than two languages. The term *trauma* refers to an event or series of events which,

overwhelm the ordinary systems of care that give people a sense of control, connection, and meaning... Traumatic events are extraordinary, not because they occur rarely, but rather because they overwhelm ordinary human adaptations to life... The confront human beings with the extremities of helplessness and terror, and evoke responses of catastrophe.

(Herman, 1992, p. 33)

This study recognizes that trauma may be related to immigration and/or other events and life experiences.

Overall, there is a dearth of literature that focuses on trauma treatment in two languages. A significant number of people are navigating the world in two languages, and the need to further understand the dynamics of processing trauma in multilingual—especially Spanish, English—therapy is great. One reason for this is because, currently, one in five U.S. residents speak a language other than English at home, with Spanish being the most common. Over forty percent of the individuals who speak a language other than English at home report limited proficiency in English (Center for Immigration Studies, 2014).

Many, but not all, individuals in the U.S. who speak another language have a history of immigration. In 2013, an estimated 41.3 million immigrants comprised 13.1% of the national population (Center for Immigration Studies, 2014). Experiences of immigration to the U.S. are varied and diverse. However, for many, the experience of immigration can be one of trauma—trauma due to events before migration, during transit, and hardship and marginalization in the new country (Foster, 2001). Although experiences of immigration are diverse, immigrants overall have disproportionately high rates of poverty in the U.S. (U.S. Census Bureau, 2007).

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The current prevalence and characteristics of immigrant populations suggest that social workers will encounter individuals affected by issues related to immigration and trauma. At the same time, reports observe that, in the U.S. immigrants are less likely to utilize mental health services than natural-born U.S. citizens. Studies document that the reasons for this are connected to “language barriers, lack of bilingual therapists, and excessive reliance on interpreters” (Kokaliari, 2012, p. 378).

Another reason for the study is that recent arrivals are settling in communities that have not traditionally been immigrant destinations (Park, Bhuyan, Richards, & Rundle, 2011). This means that service providers, perhaps unaccustomed to working with immigrant populations, are being called upon to provide ethical and appropriate services to “diverse groups of economically, politically, and socially marginalized newcomers” (Park et al., 2011, p. 368). A better understanding of clinicians’ experiences of processing trauma in two languages will support the delivery of ethical and appropriate services to marginalized newcomers.

In this way, this research topic is of special relevance to the field due to its commitment to serving oppressed and marginalized populations. The National Association of Social Work (NASW) expresses that part of the field’s mission is to “enhance human well-being and help meet the basic human needs of all people, with particular attention to the needs and empowerment of people who are vulnerable, oppressed, and living in poverty” (NASW, 2008). Multilingual clinicians are often the ones providing such services, yet there is a gap in the literature that describes the experiences of these clinicians.

It is urgent to have better understanding of experiences of clinicians providing multilingual services. To that end, the study will examine ways that multilingual clinicians process trauma with individuals in more than one language; paying attention to the ways

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clinicians think about language in therapy, what they observe about transference and countertransference, as well as conceptualize their use of self. Insights from the study can be used to ensure quality of services for multilingual individuals, as well as provide adequate training for multilingual clinicians. The study will provide valuable insights for practicing clinicians, educators, and policy makers. In addition to benefitting the field of social work, the study aims to benefit participants by providing a space for clinicians to reflect on their work, thus supporting a contemplative clinical practice.

CHAPTER II

Literature Review

The purpose of this study is to explore the experiences of multilingual clinicians in processing trauma with Latino/a multilingual immigrant populations in the U.S. in two languages—Spanish and English. This section is comprised of four major sections. Each section briefly addresses some of the issues relevant to the study, as a comprehensive exploration is beyond the scope of this paper. The first section looks at ways that the US-based field of social work understands experiences of immigration. A brief review of trauma—theoretical conceptualizations and treatment—and how it relates to multilingualism follows. Next, attention shifts to what the literature tells us about multilingualism and implications for therapy. This section synthesizes research about engaging in therapy with individuals who speak more than one language—as well as identify gaps in the field’s exploration of the topic. The final section centers on research that discusses ways that multilingual clinicians conceive of their role as therapists.

Researcher Positionality

Before moving into these topics, I feel it is important to situate myself as the researcher—my position and process of engaging with these topics. My social identity and location is comprised of areas of privilege and of oppression. I identify as a female, mixed/multi-ethnic (Latina, White), fourth generation immigrant to the U.S. from Puerto Rico. I am a U.S. citizen and hold middle class socioeconomic status. English was my first language. Although my

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nuclear and extended family speaks Spanish, I learned Spanish mainly in school and abroad, beginning in pre-adolescence. As a daughter and granddaughter, I have witnessed and experienced some of the ways that immigration and acculturation affects families and individuals—losses and gains. As a social worker in training—engaging in therapy in Spanish and English—I have also observed patterns and hold questions about language and therapy. These experiences shape some of the way I view the topics discussed in this section.

As the researcher, I chose to focus the study on therapy happening in both English and Spanish, as opposed to other or multiple languages, for a few reasons. First, it felt important to limit which languages the study examine. The study is interested in exploring what therapists observe about language while processing trauma in more than one language. It is possible that clinicians will notice different themes, issues of translation, transference and countertransference based on the two languages used in session (ex. Spanish and English, vs. Korean and English, vs. Russian and English). I chose to focus on Spanish and because Spanish is one of the most commonly spoken languages in the U.S. The field needs multilingual, Spanish-speaking clinicians, yet not much is understood about the dynamics of such therapy. It is hoped that further study of these issues will help improve the quality of services for multilingual—English, Spanish—populations. I recognize that not all Spanish speakers identify as Latino/a, and chose to include this identifier in my research as a way to explore experiences and attitudes social workers might have while engaging in treatment with individuals who identify in this way.

I am aware that I approach these issues—of language, relationships, power, healing, etc.—not objectively, but subjectively and influenced by my own beliefs and lenses. It is important to recognize I am examining these issues through lenses of feminism, postmodernism,

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decolonization, and anti-racism. Throughout this process, I am attempting to balance my own biases and be aware of the ideas that impact my thinking and research.

Social Work Perspectives on Immigration to the United States

As this study focuses on immigrant populations, it is useful to briefly review some of the ways that the field of social work understands experiences of immigration. Studies (Ainslie, Tummala-Narra, Harlem, Barbanell & Ruth, 2013) suggest that psychodynamic theorizing, which clinical social work draws upon, about the experiences of immigration has been slow to develop. Ainslie et al. (2013) suggest that this significant gap in the literature exists because classical theories' treat topics regarding culture, class, and race as nontraditional, as secondary to the individual's inner psychology.

Relational and intersubjective thinking seem to help the field see the importance of external social realities—that they are not separate, secondary entities—and that one cannot theorize about the experience of immigration without theorizing about the social realities (Ainslie et al., 2013, p. 670). Similarly, object relations theories appear to help the field examine the many dimensions present in the experience of immigration—and of language use. This chapter will discuss and examine the ways that this happens. As an example, we can turn to the writings of Eng and Han (2000).

In discussing experiences of immigration, Eng and Han (2000) discuss racial melancholia. They explain this as a sort of irresolution of the psychic and material processes of assimilation from one country, language, set of beliefs, way of life, to another. Unlike traditional conceptions of melancholia, racial melancholia may or may not be pathological. Speaking to this, they write, “from this particular vantage melancholia may be thought of as underpinning our everyday conflicts and struggles with experiences of assimilation, immigration, and

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racialization” (p. 56). In this sense, melancholic loss and racial melancholia are part of the fabric of assimilation, immigration, and radicalization within the sociocultural context of the U.S.

Kokaliari (2012) notes that “discrimination, stigmatization, and oppression also add to the chronic obstacles and traumatic experiences that immigrants must confront” (p. 376).

Exploring these issues further, theorists like Falicov (2014) consider the role of migration narratives. Like Eng and Han (2000), Falicov (2014) believes that immigration is not a pathological event. However, for most people, it is a stressful event—a stressful event that involves ambiguous losses and gains. Kokaliari (2012) notes that,

immigration is a complex psychosocial and socioeconomic process that has long-term effects on the person and on identity...profound loss is common to the experience of immigration—of loved ones, status, cultures, values, familiar lifestyles, a sense of safety, and even beloved personal belongings. (p. 375)

Falicov (2014) notes that it can be helpful for individuals and families to construct a migration narrative as a way to understand the meanings of migration events and relational stressors that may have followed (p. 102). These narratives can be constructed verbally or through other artistic mediums, and consist of the three types of uprooting that Falicov discusses: physical, social, and cultural (p. 102). Falicov notes that, in situations where a migration is a traumatic event, “utilizing therapy approaches that require talking about traumatic events poses the risk that clients will feel retraumatized by the recounting” (p. 109). Nevertheless, she states, “studies of testimony therapy contradict the idea that it is not helpful to tell the trauma story, and they demonstrate its effectiveness when conducted by psychotherapists trained in this type of work.” She does not comment on the role of language in constructing migration narratives, although she does discuss the loss of language that can happen with migration.

Trauma and Immigration

While Eng and Han (2000) discuss loss in the context of immigration, Ainslie et al. (2013) point out that very few studies have explored the experiences of trauma in the context of immigration. Falicov (2014) adds that, “the possibility that migration involves trauma has been less explored for economic immigrants than it has been for refugees (p. 107).” There is no universal experience of immigration, there is great diversity of experiences—some traumatic and some not. And even for those who have traumatic experiences, not all will develop Trauma Related Disorders.

Keeping this in mind, Foster’s 2001 study, as cited in Ainslie et al. (2013), is a foundational study which attends to specific ways that trauma and immigration can overlap. Foster points to four periods of the process of migration in which trauma can have a unique influence:

(a) single or cumulative events prior to migration contributing to dislocation (e.g., war exposure, torture, natural disaster), (b) traumatic events during the transit (e.g., parental separation, death of traveling companion, forced labor or exploitation), (c) continued rejection and hardship in the new location, and (d) chronic substandard living conditions in the new country (e.g., lack of income, inadequate support, discrimination). (Ainslie et al., 2013, p. 674)

Similarly, Kokaliari (2012) recognizes the cumulative stressors of immigration, which can often have traumatic and chronic effects (p. 375). However, while immigration can be a trauma, it is not always. Kokaliari (2012) discussed the various factors that influence how a person adjusts and adapts to their new life. She identifies these factors as: 1) age at the time of immigration (children sometimes adjust faster than adults), 2) type of immigration (migration for

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an indefinite vs. finite time period can be easier to adjust to), 3) whether the person immigrates alone or with support, 4) whether immigration is voluntary (can find more trauma and grief in refugee and asylum seekers), 5) how much time a person had to prepare (p. 375-6). There is no universal experience of immigration, there is great diversity of experiences—some traumatic and some not. And even for those who have traumatic experiences, not all will develop symptoms of Trauma Related Disorders. In this spirit, Oxford's 2005 study suggests that social workers be mindful of the potentially harmful effect of rescue narratives, especially when immigration and trauma are part of the picture.

Conceptualizations of trauma and healing. The concept of trauma is widely discussed in the field of social work and does not have a sole definition. In her seminal book, *Trauma and Recovery*, Herman (1992) defines trauma as an event or events which,

overwhelm the ordinary systems of care that give people a sense of control, connection, and meaning... Traumatic events are extraordinary, not because they occur rarely, but rather because they overwhelm ordinary human adaptations to life. Unlike commonplace misfortunes, traumatic events generally involve threats to bodily integrity, or a close personal encounter with violence and death. They confront human beings with the extremities of helplessness and terror, and evoke responses of catastrophe. (p. 33)

People respond to traumatic event(s) in different ways. Some people have greater resilience or ability to cope with trauma. (Chu, 2011). There is a spectrum of traumatic responses, which can alter the way people think about the world, relationships, and themselves—from natural recovery, to Dissociative Identity Disorder (DID), and posttraumatic stress disorder (PTSD) (Herman, 1992, p. 3).

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Chu (2011) notes that the severity, how long it is prolonged for, and stage of life in which the trauma occurs impacts whether someone will develop a Trauma Related Disorder. In addition to this, Chu cites research which suggests that an individual is at greater risk of developing Trauma Related Disorders, in this case PTSD, given “preexisting psychiatric disorders, adverse childhood experiences, lack of social support, low socioeconomic status, lower intelligence, and family history of mental illness and/or substance abuse” (p. 28).

The field of social work is host to various modalities and of understanding and treating trauma as well as trauma-informed treatments. An overview of such treatments is beyond the scope of this chapter, however we can identify some commonalities. Herman (1992) advocates that the fundamental stages of recovery from trauma are “establishing safety, reconstructing the trauma story, and restoring the connection between survivors and their community” (p. 3). Many treatment modalities incorporate some of these elements; emphasizing different aspects.

The role of trauma narratives. Many models of treatment include the creation or expression of a trauma narrative, which can support processing and integration of the traumatic event. Trauma memories are often disorganized, containing verbal and nonverbal components, and various affective content. A study by Pennebaker and Seagal (1999) suggests that talking about trauma memories may help organize, process, and integrate traumatic experiences.

Additionally, many orientations hold that healing is possible without a full written/verbal narrative. There also exists non-verbal treatment, such as Eye Movement Desensitization and Reprocessing (EMDR), which focuses on integrating emotional material into the traumatic memory (Shapiro & Maxfield, 2002). These less narratively-focused models seem to build off of the idea that, when it comes to trauma, some survivors experience a “speechless terror” (van der Kolk, 1997, p. 251). van der Kolk (1997) goes on to observe that, “in some people the memories

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of trauma may have no verbal (explicit) component at all; the memory may be entirely organized on an implicit or perceptual level, without an accompanying narrative...” (p.252). In this way, a trauma narrative may support the organizational process, or the trauma may be processed in another, non-verbal manner. It appears that more research is needed to understand the role language plays in processing non-verbal and pre-verbal trauma with individuals who speak more than one language. This also applies to trauma therapy in general, as few studies explore issues related to treating trauma in more than one language, despite the wealth of literature on treating trauma in monolingual populations.

Trauma narratives and multilingualism. Of the studies that do examine the intersections of multilingualism and treating trauma, many comment on the ways that language functions in relation to the traumatic event(s). A study done by Javier (1993) suggests that memories are best recalled in the language in which they happened. This language matching—of life experience and recall—allows people to express memories with greater detail, vividness, and affect. Pérez Foster (1998) suggests that additional languages in treatment can be effective ways of repressing—or isolating—traumatic and conflicting experiences (p. 100). Similarly, Burck (2002) notes that using another language to recall trauma is sometimes a way to protect oneself from the trauma narrative. Alternatively, it can be a way to “challenge atrocity by reclaiming language” (Burck, 2002, p. 78)—it depends on the individual. People who speak more than one language may use language to both gain distance from, and approach traumatic narratives. Kokaliari’s 2012 article—which focuses specifically on bilingual immigrant—observes similar language relationships. When expressing trauma, Kokaliari (2012) suggests that clients can use language in ways that help them avoid and access painful content as well as separate and integrate trauma memories. She observes that returning to the “mother tongue”—which can be

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laden with affect, memories, and relational constructs—can be a source of powerful healing (Kokaliari, 2012, p. 382).

Kokaliari, Catanzarite and Berzoff (2013), in a qualitative study, observe that people who speak more than one language often spend more energy narrating their stories. In their review of the literature, Kokaliari et al. (2013) find that the extra energy necessary to communicate a narrative in a secondary language simplifies and modifies complex experiences (p. 99). Their study findings suggest that, for this reason, narratives of trauma—in all their complexity—can be particularly difficult to express in a second language.

Theories of Multilingualism

Many disciplines such as linguistics, neuroscience, and psychoanalysis theorize about the phenomenon of speaking more than one language, or multilingualism. These fields explore ways that speaking more than one language affects the brain, an individual's experiences of themselves, the world around them, and the ways they relate to it. Lee and Kim (2010), for example, suggest that speaking more than one language is a skill that supports innate cognitive abilities and personal strengths. Things like creativity, adaptability, and intellectual elasticity are likely reinforced through learning and speaking more than one language. In the past, bilingualism has also been viewed as a negative. A full review of theories on multilingualism is beyond the scope of this study. However, the field of social work draws from these theories to understand dynamics of speaking more than one language.

Compound and coordinate bilinguals. In the 1950s to the 1970s especially, there was much psycholinguistic research and debate on bilingualism. The idea of compound and coordinate bilinguals developed from that period, originally introduced by Weinreich (1953). The idea is that there are two different kinds of bilinguals who use different kinds of cognitive

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processes to organize their experiences. “Compound bilinguals” refers to people who acquired two languages from early childhood. For compound bilinguals, corresponding words in multiple languages are connected to a single set of concepts. “Coordinate bilinguals” refers to people who learned another language at a later stage of development. For these bilinguals, there are multiple sets of concepts, each with its own language symbol (Pérez Foster, 1998).

Research by Albert and Obler (1978) challenged the strict distinction between compound and coordinate bilinguals. It is now commonly believed that all bilinguals have partially compound and partially coordinate systems. In this way, neither language system is wholly interdependent or independent from each other (Pérez Foster, 1998). To understand the role of language for individuals who immigrate to the U.S.—in addition to paying attention to when and under what circumstances they learned Spanish and English—studies (Burck, 2002; Kokaliari et al., 2013) point to the importance of considering their level of acculturation.

Language as an organizer of experience. Pérez Foster’s seminal work *The Power of Language in the Clinical Process: Assessing and Treating the Bilingual Person* (1998), synthesizes theories on bilingualism to explore the roles that languages play. According to Pérez Foster (1998), language is important to development and as mental organizer of experience. The environment, the relationships, and the internal psychological state of an individual at the time of language learning will be deeply linked to the language itself. Each language an individual speaks carries a unique meaning, connected to a particular set of life experiences (Pérez Foster, 1998, p. 115). In her analysis, she considers early object relations and asserts that early experiences of attachment are embedded in language. Similarly, Kokaliari et al. (2013) observe that language is encoded with the tone of early caregiving.

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The foundational work of Marcos, Urcuyo, Kesselman, and Alpert (1973) supports Pérez Foster's idea that the context of language acquisition is deeply linked to the language itself.

These researchers developed the idea of language systems, and assert that, "people who speak different languages live in different worlds, not in the same world with different labels attached" (Marcos et al., 1973). Marcos, Eisma, and Guimon (1977), observe that, because each language is coded in a particular set of experiences, people who speak more than one language sometimes express a "dual self."

Through her theoretical study, Burck (2002) adds that different views and assumptions about the world are encoded within each language. People who speak more than one language, then, tend to have different experiences of their self in each language. Other studies have observed these shifts in values and—together—suggest a connection between bilingualism and biculturalism that suggests languages are "contexts within which we position ourselves and are positioned" (Burck, 2002, p. 71).

Kokaliari et al. (2013) observes that the field argues about whether people who speak more than one language develop different systems of language organization—the compound vs. coordinate debate. Some research suggests that they engage in ongoing "dual processes," of functioning and feeling in both—or more—languages (Kokaliari et al., 2013, p. 98). The study suggests that, "language...operates on the level of associations and meanings that are rarely translatable" (Kokaliari et al., 2013, p. 98). Because of this difficulty translating meaning, research suggests that multilinguals have different experiences from language to language—different languages hold different worldviews. Using a second language also necessitates a sociological shift. This shift of contexts can change a person's worth or value. Furthermore, the

inability to find identical meaning in both languages may be experienced as loss (Burck, 2002; Kokaliari, 2012; Kokaliari et al., 2013).

Multilingualism and Therapy

Theories about therapy have long recognized the significance of language in the therapeutic dyad. When it comes to the multilingual dyad, however, there is comparatively little written (Iannaco, 2009). Studies (Pérez Foster, 1998; Kokaliari, 2012; Kokaliari et al., 2013) that do attend to the subject suggest that, when it comes to therapy, it is important to engage multilingual individuals in multilingual treatment. Pérez Foster (1998) observes that if a client speaks more than one language, it is necessary to work in their native language and other languages they've acquired. It is thus necessary to consider language during all phases of treatment (Pérez Foster, 2001). For example, she notes that “the language of assessment has some impact on the manifest expression of cognitive pathology” (p. 164), which suggests that—depending on language—individuals' clinical presentations and psychological structure vary. Clinicians have noted that individuals speaking in a second language, for example, may present with detached affect or to lack experiential and emotional integration of experience and emotion, versus in their first language. Furthermore, an individual speaking in their first language may present as more disorganized than in a second language, which may serve a distancing purpose from charged affect (Pérez Foster, 2001).

Language and acculturation. As discussed earlier, it is important to take into account level of acculturation when working in the U.S. with immigrant populations who speak Spanish and English. In this spirit, Burck (2002) importantly calls attention to the fact that, in certain contexts, to speak or to learn English is to speak the language of the oppressor. Foster (2001) explores this issue further and discusses it in terms of “second-language anxiety” (p. 164). This

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anxiety, she suggests, is about being perceived as “passive, inarticulate, simple-minded, or unsophisticated in a second-language, which one knows is not expressing the full compliment of one’s thoughts and feelings” (p. 164). Furthermore, for some immigrants, to try to express oneself in English is to try to express oneself in the language of those in power—the oppressor. In this sense, language is the “oppressive other.” Speaking English, then, may lead to interactions in which one is “cautious, inhibited, unexpressive, passive, and possibly deferential” (Pérez Foster, 2001, p. 164). Foster (2001) notes that this can lead to many tensions and expressive difficulties in the therapeutic relationship.

Switching. Many scholars (Iannaco, 2009; Kokaliari, 2012; Kokaliari et al., 2013; Pérez Foster, 1998) acknowledge language’s import and assert that language use in multilingual therapy dyads is clinically important. Language use must be attended to—in part for the reasons discussed below. Much of the literature (Iannaco, 2009; Kokaliari, 2012; Kokaliari et al., 2013; Pérez Foster, 1998) references the phenomenon of switching from one language to another in multilingual therapy dyads. Studies (Iannaco, 2009; Kokaliari et al., 2013; Pérez Foster, 1998) suggest that clinicians need to track language switching in sessions. Iannaco (2009), in her theoretical article, suggests that this—sensitively observing patterns in language switching and the ways a person interacts with the languages—can provide insight into individual’s psychological state, hopes, dreams, and conflicts (p. 262). Burck (2002) observes that switching languages can connote intimacy. In Paraguay, when some people begin courting, they do so in Spanish. However, as they become more intimate, more and more they switch to Guarani (Burck, 2002).

Kokaliari et al. (2013) also note that individuals shift from one language to another when communicating intimate or emotional issues. This can be especially true when the content

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someone is communicating is associated with different meanings in the different languages (Kokaliari et al., 2013, p. 99). Pérez Foster (1998) also suggests that differential use of language—including switching—can function as “psychic defenses, as a mechanism of repression, as a neutralizer of early desires, and a symbolic signifier of internalized self-representations” (p. 105).

Multiple language-based selves. As discussed above, many studies (Litjmaer, 2011; Burck 2002; Kokaliari, 2012; Kokaliari et al., 2013) suggest that people who speak more than one language experience “multiple language-based selves” (Pérez Foster, 1998). Thus, the language that the multilingual individual chooses in a particular moment—often unconsciously—impacts both the content and manner of communication. Although this literature suggests that the ways multilingual people use language is clinically important—especially when communicating emotional content—few studies focus specifically on the dynamics of trauma when exploring the phenomenon.

Role of the Multilingual Clinician

Existing literature on practicing therapy in more than one language suggests that it comes with additional responsibilities for the therapist. Walsh (2014), Kokaliari (2012), and Burck (2002) suggest that it is important for clinicians to unpack their language issues. Kokaliari (2012) notes that, “the therapist must understand the role and use of both his or her language and the client’s language” (p. 392). She goes on to discuss the importance of discussing the role of language with clients, in order to open up space for clients to express how different languages can shape the way they experience the self, identity, and emotional expression. Similarly, Burck (2012) holds that, clinicians who practice in more than one language have a responsibility to help clients consider experiences and narratives that are specific to language in the process of therapy.

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In her theoretical article, she defines unique dimensions in the multilingual therapy dyad. These dimensions include an individual's "different experiences in different languages, the effect of conducting relationships in different languages, issues of finding a liberational voice, and the living of multiple identities" (Burck, 2002, p. 76). The multilingual therapist and client appear to be tasked with meaning-making in additional dimensions. Lijtmaer (2011) would appear to agree, with her statement that "conducting therapy in a patient's first or second language as additional responsibilities to the analyst." She suggests that these clinicians have the duty of "being aware of and listening to the inner translation process and the phantasies and defenses that surround it" (p. 269).

Transference and countertransference. Much of the literature that examines the dynamic of multilingual therapy includes observations about transference and countertransference. However, as Kokaliari (2012) notes, transference and countertransference in multilingual therapy have received little attention overall, despite its importance. She goes on to discuss the significance of language and cultural factors in transference and countertransference, saying that, "Culture and language function in the unconscious. If a clinician is not attentive to the unconscious meaning of language and culture, therapeutic ruptures may occur" (p. 388).

In her 2011 theoretical article, Lijtmaer summarizes different possibilities for transference and countertransference when therapy happens in more than one language. In discussing transference when the client and clinician are both bilingual, Lijtmaer notes that individuals may idealize the therapist, as well as reveal ambivalence. In terms of countertransference, Lijtmaer discusses a therapist's fear of over-identification with the clients, a fear of losing a "neutral stance" (p. 619), as well as a need to prove competency in another

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language. She also considers a therapist's own history of immigration and relationship with the languages spoken to be significant elements in transference and countertransference.

Walsh (2014) seems to agree with Litjmaer (2011), and delves deeper into these layers of transference and countertransference, as she discusses “multiple language based selves” of the therapist and client (p. 60). Walsh’s (2014) “multiple language based selves” refers to who we are in a particular language, as well as the nature of the relationships co-created by the therapist and client in each language. Walsh observes that different languages can open up new relational possibilities, new transference and countertransference possibilities (p. 67).

Kokaliari et al. (2013) conducted a qualitative study—one of the few that explore the experiences of multilingual clinicians—that looked at therapists’ understanding of the role of language in therapy with bilingual clients. Their findings suggest themes of transference and countertransference similar to Litjmaer (2011), Walsh (2014), and Kokaliari (2012). In the area of transference, the study observes that, “language differences may trigger issues of trust, hostility, or idealization toward the therapist” (p. 110). Speaking the same language can also stir up issues of intimacy and judgment. In the area of countertransference, the study observes that therapists may feel pulled to over join with the client, which could contribute to not addressing important issues in therapy. Additionally, therapists may feel anxiety about proving language proficiency.

In discussions of both transference and countertransference, participants in the study spoke of the significance of the dyad’s cultural identifications and immigration status. For example, the study notes that in cases where the client and clinician are from the same culture, clients may expect to be fully mirrored, and/or to feel too close, or judged by the therapist. The study notes that these therapists may invest more time with clients of the same culture, or join

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with clients in an effort to meet the therapists' need to engage with their heritage. The study also discussed cases in which the therapist was from the dominant culture, which may evoke skepticism in the client about whether the therapist can really understand them. Additionally, immigration status can evoke questions in the therapist, such as "Do they [the client] view me as having sold out? Or as an immigrant that has performed better than them? Do they view me as an immigrant that shouldn't be here?" (Kokaliari et al., 2013, p. 111).

Like Kokaliari et al. (2013) and Litjmaer (2011), Walsh (2014) considers the therapists' own relationship with the languages spoken to be relevant in therapy. For therapists practicing in more than one language, Walsh believes that it is essential to explore "language transference" and how—and who—a therapist is in all the languages in which they practice (p. 69). This appears to be one of the responsibilities of multilingual therapists, more of which are explored below.

Need for multilingual services. In the current context of the U.S., there is a clear need for language-appropriate services, and thus demand for multilingual clinicians. Research from Biever, Castaño, de las Fuentes, Gonzalez, Servin-Lopez, Sprowls, and Tripp (2002) suggests that individuals who learned Spanish at home or in similar social contexts are usually more comfortable discussing intimate issues in Spanish than English. This suggests the language preference is an important factor in delivering mental health services. At the same time, reports observe that, in the U.S. immigrants are less likely to utilize mental health services than natural-born U.S. citizens. Studies document that the reasons for this are connected to "language barriers, lack of bilingual therapists, and excessive reliance on interpreters" (Kokaliari, 2012, p. 378).

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In a qualitative study, Engstrom, Piedra, and Won Min (2009) describe that, despite the demand, little is known about the ways that language shapes the work of bilingual social workers. Their study explores how bilingual social workers use their language skills and their perspectives on bilingual work. Their findings also suggest that bilingual social workers often carry higher (bilingual) caseloads without higher compensation. Many participants note that these bilingual cases often require more time and energy than monolingual cases. Additionally, the study suggests that multilingual therapists are likely not getting the ongoing linguistic training they need to navigate the dimensions of social work in more than one language. It is important to note that, while the study points to important issues, they need to be explored more in further research. The study is limited in terms of number of participants and location of study (San Diego, CA). Their findings cannot represent the field at large.

Conclusion

Although there is a documented and growing need for multilingual therapeutic services, factors such as language use and multilingualism has not been amply explored (Santiago-Rivera, 1995). It appears that, overall, there is a dearth of literature that explores the experiences and perspectives of multilingual therapists. Kokaliari et al. (2013) call for further qualitative research in this area, which is why this study aims to gain a deeper understanding of what clinicians observe in treating trauma in Spanish and English, what their understanding of the role of language is, and how it impacts treatment. The central question of the study is: What are the experiences of clinicians in processing trauma with Latino/a immigrant populations in the U.S. in two languages—Spanish and English?

CHAPTER III

Methodology

Research Purpose and Question

As discussed in the previous chapter, more research is necessary to increase our understanding about the experiences of multilingual clinicians in processing trauma with Latino/a multilingual immigrant populations in the U.S. in two languages—Spanish and English. Specifically, past qualitative studies indicate the need for more exploratory, qualitative studies in which clinicians can reflect upon and share their experiences (Kokaliari et al., 2013).

The purpose of this study is to investigate the following research question: What are the experiences of clinicians in processing trauma with Latino/a immigrant populations in the U.S. in two languages—Spanish and English? I conducted a qualitative, exploratory study to answer this research question. I developed a flexible study which can deepen and enrich our understanding of the phenomenon without a formal assumption about the actual nature of the relationship between language, trauma, and immigration. The results of this study has implications for service delivery to vulnerable and oppressed populations, as well as needs for training—graduate level and ongoing—for clinicians working with immigrant populations in more than one language.

Research Method and Design

Since there is currently little research on the study question, I engaged in a flexible methods research process. As flexible methods dictate, I developed an interview guide with semi

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structured, open-ended questions. The questions aim to gather narrative data from study participants.

One advantage to conducting an exploratory qualitative study, versus another study design, is that it gives the researcher space to explore participants' perspectives on the research topic, instead of aligning responses to pre-assigned categories (Engle & Schutt, 2013). The study is not setting out to prove any given hypothesis. It seeks to gather the voices of multiple clinicians in order to better understand their experiences.

Due to its subjective nature, an exploratory qualitative study also has limitations. As the researcher, I will approach interviews with my own perceptions and beliefs, which may impact the way I understand and interpret participant responses. The outcome of the interviews depends on both my interpretation, as well as what I include or omit. Although my perceptions will inevitably inform my interpretation of themes, I will attempt to strengthen reliability and decrease bias, by relying on peer review and member feedback.

Sample

I interviewed 10 licensed clinical social workers who have experience working in more than one language (English and Spanish) with individuals who speak both Spanish and English, identify as Latino/a, have a history of trauma, and identify as having a history (personal, familial) of immigration to the U.S. Since the study is exploratory in nature and I do not plan to generalize the findings to the larger population, I used non-probability sampling. I used a purposive, snowball sampling technique to recruit participants.

Participants met the following criteria: 1) participants must be currently licensed clinical social workers in the United States; 2) participants must speak and practice therapy in both Spanish and English; 3) participants must have experience engaging in therapy with clients who

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speak both Spanish and English, identify as Latino/a, have a history of trauma, and identify as having a history (personal, familial) of immigration to the U.S.; 4) participants agree to participate in the study. I made efforts to recruit a diverse sample with respect to race, ethnicity, gender, age, immigration experience, and varied professional work experiences.

Recruitment. I began by identifying participants by contacting staff at Massachusetts General Hospital HealthCare Center in Chelsea, MA, my internship site. I did this through in-person conversations, flyers, emails, and announcements at staff meetings and team meetings (Appendix C, Appendix D). In the early stages of recruitment, I amended outreach materials in order to clarify the focus of the study. I also reached out to professors and classmates at Smith College School for Social Work by email (Appendix C) who may be eligible to participate and/or identify other participants. Additionally, I reached out to licensed clinical social workers working within the San Francisco Unified School District by phone and email. I contacted potential participants by phone and/or email and/or video-conference. My outreach requested participants as well as referrals for participants. If clinicians know of potential participants, I asked that they pass on my contact information or for permission to reach out to them directly. I also posted information about the study to professional social work groups and/or pages on Facebook (Appendix C, Appendix D).

In my conversations with potential participants, I described the study—including potential risks, benefits—and inquired whether they and/or anyone they know might have interest in participating in my study. I screened potential participants by 1) clearly stating participants requirements in my initial outreach and 2) through a brief conversation or email exchange in which I determined whether they are interested and able to participate in the research: they meet the participant criteria, they agree to be interviewed. Participants included

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staff with whom I worked at Massachusetts General Hospital in Chelsea, MA. I did not interview individuals without discussing this dual relationship and any potential conflicts of interest. If together we identify conflicts of interest, I will not interview them. For example, I will not interview anyone with whom I have a current supervisory relationship. If the potential participant expressed interest and met participant requirements, I scheduled time for an individual interview in order to answer any questions and discuss and obtain consent. If it is not possible to obtain consent in person, I obtained consent by mailing consent documents with a pre-stamped return envelope to be returned to me prior to any interview. I made efforts to provide space for participants and potential participants to ask questions during screening conversations, as well as when obtaining consent.

Data Collection Methods

I planned to meet with participants at least twice: once to discuss the research project, participant and consent, and second time to hold the interview. With some participants, I had additional interactions with participants prior to the interview—for example, if they had additional questions about the study and their participation—as well as after the interview.

Data was collected through semi-structured interviews about social workers' experiences working in multiple languages. Domains include: issues encountered, perception of role language in therapy, and clinician's theoretical orientation. For example, I asked the following questions: 1) Before we get further into this interview, I'm wondering about your first impressions of the role of language in therapy? As a multilingual clinician?, 2) In your experience, what have you noticed about your multilingual clients' use of language?, 3) What are your experiences with clients expressing trauma experiences in more than one language and/or a

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second language? Can you provide any case examples?, and 4) What sorts of challenges do you face as a multilingual therapist? (Appendix A).

Interviews ran for about one hour, depending on the length of participants' answers. Interviews were held in-person in the Boston Area or via video conference/phone. It is important to consider the effects of this data collection method on the interview—especially issues regarding participant concerns about confidentiality, participant level of comfort communicating online, etc. In cases of video conferencing, steps were taken to make sure that both the participant and researcher are in quiet, private locations. Participants' responses were audiotape recorded on a hand-held digital audio-recording device.

The researcher also recorded details of participant responses through written notes, which were taken during the interview. All research materials including recordings, transcriptions, analyses and consent/assent documents 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. In this study, anonymity is not possible since interviews will be face-to-face. Privacy is maintained by de-identifying information collected and protecting all identifying information by storing it separately from the data.

Ethics and safeguards

I identified three major ethical concerns while designing this study. These concerns center around consent, confidentiality, and the potential for discomfort. I built several measures into the study to address these concerns.

To address concerns about consent, all participants read and signed informed consent forms approved by Smith College School for Social Work before participating in the study. At

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the start of the interview, I reminded participants that I would be recording the interview and asked whether they were ready to proceed.

To address concerns about confidentiality, all consent forms, interview notes, and any printed transcriptions are kept in a lockable file drawer during the thesis process and for three years after, as federal regulations require. After three years I will either destroy the material described above or maintain it in this secure fashion. All electronically stored data is password protected during the storage period. Privacy is also be maintained by: de-identifying information and protecting all identifying information by storing it separately from the data. Consent letters will be kept separate from notes and transcripts, and each participant will be assigned a code number, which will be placed on all materials. Video/audio recording digital files are be password protected. I collected some demographic data, and use this data only to describe the sample. I did not connect the demographic data to specific study participants, consistent with maintaining participant confidentiality.

It is possible that participants may feel uncomfortable during the process of discussing their therapy processing trauma with individuals. As this is an exploratory study and interview, participants will not be pushed to discuss experiences that they do not wish to. To address this concern of possible discomfort, participants were told that they could decline any question, as well as end the interview for any reason. The researcher, also a clinician in training, took steps to observe/monitor non-verbal signs of discomfort and/or distress and attempt to avoid participant discomfort and/or distress.

Data Analysis

I recorded the narrative data through audio-recording during interviews. After interviewing, I transcribed the interviews verbatim from the audio-recordings. I conducted a

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content/theme analysis as the method to code and analyze the data. Using the open coding method, I processed and organized the qualitative data I collected through the interviews. I then looked for patterns among themes that yield insights related to the research question.

Discussion and Conclusion

The purpose of the proposed study is to investigate the following research question: What are the experiences of clinicians in processing trauma with Latino/a immigrant populations in the U.S. in two languages—Spanish and English? My hope is that the findings of this study will raise awareness of and contribute to the field's growing knowledge of dimensions of trauma therapy occurring in multiple languages. The study is also interested in observing how clinicians think about language, navigate issues of transference and countertransference, and conceptualize their use of self, depending on language. The results of this study may have implications for service delivery to vulnerable and oppressed populations, as well as needs for training—graduate level and ongoing—for clinicians working with immigrant populations in more than one language.

I approached the study sensitive to ethical concerns. One central concern I've identified thus far centers around confidentiality protections. This is of central importance, since when asking participants to share experiences in the field, it opens the door for them to discuss sensitive client information—many of whom may be vulnerable and experiencing oppression. I took precautions to make sure that all (multi-layered) identifying information is concealed.

Due to the sampling technique and the exploratory nature of the study, the results are not generalizable to social workers as a whole. This is not the aim of the study. Instead, the aim is to observe and collect narrative data related to the ways clinical social workers think about

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language, navigate issues of transference and countertransference, and conceptualize their use of self in the context of this particular therapeutic dyad.

Considering this, there are a number of limitations in this study. For one, the sample size of the population is relatively small, given the nature of the study and resources allocated. The sample was limited to practicing clinicians in the Boston Area of Massachusetts—given my initial “snowflake” contacts. It is possible that clinicians in this geographic area responded differently than in the rest of the United States. It is also important to note that participants are located in a geographic area that has been a traditional destination for immigrants, and thus their attitudes toward treatment may differ from clinicians newer to multilingual work with immigrant populations.

Retroactive self-reporting of the interviews could be another limitation. Yet, an open dialogue will allow me to explore the ways in which individual clinicians conceptualize dimensions of their work with multilingual immigrant populations. In the future, building on this and other studies’ exploratory findings, the field of social work could benefit from examining issues working within various language abilities—of clinician and client. Additionally, similar larger-scale, mixed methods studies could be appropriate.

CHAPTER IV

Findings

The purpose of this study is to gain insight into clinicians' experiences of multilingual therapy with individuals who have histories of trauma and immigration. The central question of this study is: What are the experiences of clinicians in processing trauma with Latino/a immigrant populations in the U.S. in two languages—Spanish and English? In order to explore this area, the researcher conducted semi-structured interviews with clinical social workers (n=10). Of the participants interviewed, all identified as female, nine identified racially as White and one identified as Latina. Four social workers identified as first generation immigrants to the U.S. and five identified as second, third, or fourth generation immigrant to the U.S. Most (n=6) interviewees have between one and five years of experience engaging in multilingual therapy, with an average of three years. Three participants have over 21 years experience engaging in multilingual therapy, one person has between 11 and 15 years, and another has between 16 and 20 years. Half of the participants hold an LCSW and half hold an LICSW. Most respondents (n=9) reported that over half of their caseload consists of multilingual—Spanish and English—individuals who identify as Latino/a and have a history of trauma and immigration to the U.S. All participants also reported working with many clients who are monolingual (Spanish-speaking) who identify as Latino/a and have a history of trauma and immigration to the U.S.

Considering the participant demographics, it is important to note the limitations of these findings, as they cannot be generalized to all social workers working in Spanish and English. It is

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also important to note the potential effect of researcher bias. While the researcher has taken steps to be aware of and limit the effect of bias, the findings are filtered through the perspectives and views of the researcher

The major findings emerged in five primary themes. The themes include: language and treatment; language and trauma narratives; language, culture, and race; language and transference/countertransference; and considerations for language and the agency setting. These themes will be presented below.

Language and treatment

Importance of the first language in therapy. Almost all of the participants spoke about the importance of being able to provide therapy in the client's native language. Half of the social workers observed that doing therapy in the client's primary language help them feel understood and more comfortable. Many (n=7) also reflected on what a positive difference it can make for the social worker to be able to follow multilingual client's language use. One participant said,

I just think it's so important to do therapy in the language that the person [speaks]...I have one client that...starts every sentence in Spanish and finishes...every paragraph in Spanish...and I can follow her and I can answer back that way and I feel like it's really important to just sort of be able to follow a client in whatever language they are speaking.
(Participant 7)

In discussing the primacy of language and of language preference, one participant suggested that it, "takes a lot away from them if they choose to do something as intimate as a therapy session in a language that they are not fluent in.... (Participant 2)"

Social worker's perception of role. In discussing their role as multilingual clinicians working with individuals who have a history of trauma and of immigration, all participants spoke

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of the value of curiosity, not knowing, and respect in supporting the client meet their identified goal for treatment and understand themselves better. When asked about their perceptions of their role, five social workers also talked about the importance of the therapy relationship—of connecting, putting people at ease, and building trust. Two interviewees also talked about their role in terms of bearing witness and helping someone develop a narrative and find words for their story.

Three participants reflected that they sometimes act as a “broker” or “translator”—of communication and of cultural experiences. Participant six reflected that there is a “psycho-educational piece to it...how things work here compared to how things work in your country or different countries...” Participant three shared that, “you're not just being a therapist, you're also a translator. You do both, always, at the same time. You're not just a translator of the words, you're a translator of the whole process of the whole cultural experience...”

Language and therapeutic alliance. All participants seemed to believe that language has an impact on the treatment relationship, and that speaking in someone's primary language could be a way to get deeper and strengthen the alliance. Participant two observed that in working with a multilingual client “it took me quite a while to go into the Spanish...at that point [when the client spoke in Spanish] we had a more trusting relationship than right in the beginning.” Another social worker also discussed feeling like clients are more formal in their language use at the beginning—some would speak with her in English and then visibly relax when they found out that she also spoke Spanish, “they relax and they speak their own language...they don't pretend. They become a real person (Participant 3).” Similarly, another respondent noted that, “It [Spanish] was definitely used to when we were just comfortable with

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each other...I think she used it when she felt comfortable with me and was able to open up to me (Participant 8).”

Of the participants who learned Spanish later in life (n=8), four talked about the way that their linguistic mistakes can help the therapy relationship. Participant four stated that,

I do let them know that I'm not perfect, that I'll make mistakes and to let me know when I make a mistake...sometimes I actually think that showing this vulnerability can be helpful to the therapy, to humanize myself a little bit and hopefully show some compassion for being a second language learner...a lot of folks are trying to learn English or struggling to navigate society where English is the main language.

Client's use of language. Many (n=8) participants reflected on the importance of paying attention to that way multilingual clients use language. All participants discussed ways that things such as language preference, switching, and emotionality in language may have clinical significance.

Language preference. The majority of respondents discussed ways that they understand the client's language preference. Three reported that they discuss and choose which language to use with clients, and that oftentimes clients will use what they're most comfortable with. Others noted that clients seem to use a language based on things like: the content they're discussing (many noted that clients tend to speak about events in the language in which they happened—although they note that this isn't always the case in discussing trauma or highly emotional content), how they're feeling emotionally, clients age and language ability, as well as level of and feelings about acculturation to the U.S.

Switching. All participants commented on the phenomenon of switching in multilingual therapy. Almost all (n=9) of the respondents expressed curiosity about what the switching could

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mean and observed that it is “not always predictable,” that it “depends on the situation.” Despite this uncertainty, many (n=9) of the social workers interviewed had some working theories and ideas about how to understand it.

Five interviewees commented on the link between emotion, memory, and language. They noticed that appears more common for clients to use their first language, which for many is Spanish, when recounting a memory and/or when experiencing large affect. One social worker reflected on a case, “when she was lost in the memory, or was telling me a story about...some experience that I would label is very traumatic, that's when Spanish would happen (Participant 8).” Another subject observed that “when they've wanted to distance emotionally...from the moment or to contain emotional distress...they may speak in the language that they are not fluent. [When they are] very emotionally aroused, like anger, the first language will come out. I've had a lot of bilingual clients, if they are triggered, they come in very upset something that happened, they will speak in their native tongue (Participant 2).” Another subject noted shifts connected to memory and psychosis. She described that a client will, “hear her father's voice. I think that always in Spanish. Then she'll shift immediately back to English (Participant 5).” In this way, social workers observe that multilingual clients sometimes use language to move away from or toward affect.

Four social workers also observed patterns between swearing and language. However, the patterns were not consistent across interviews. Some (n=2) clinicians observed that clients would swear in their first language, “I've noticed [switching] more with being angry and going into Spanish to swear...Participant 2).” Others (n=2) noticed that clients swear in English. As one social worker recounted,

There is one man I see who is Dominican. We always speak all Spanish, but then if he

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swears he'll say the F word in English...It definitely has a different effect for me [than swearing in Spanish]. I don't know if that's in his intention because I know some Spanish swear words but not all of them, so maybe it's a way for him to just express how frustrated he is in a way they that will really sink in with me. (Participant 4)

Although clinicians noticed language differences, in each case discussed, the client swore in the social worker's first language.

Three participants, whose first language was not Spanish, also noticed that clients sometimes shift from Spanish to English when the social worker has difficulty understanding them. One subject commented on this, "they're trying to accommodate me and just so we can understand each other better (Participant 8)." Many (n=7) participants noticed that clients might switch languages when communicating something that was better expressed in a particular language. As an example, one social worker observed that many of her adolescent clients would use the word "whatever" when speaking in Spanish,

A lot of them say "whatever," even if we're speaking in Spanish, to describe how they don't really care about something. They're just like, "entonces yo era como 'whatever.'" ...There's this way that the English word really speaks to them, to describe the feeling of being really blasé about something. (Participant 1)

Some (n=5) subjects also observed that clients might switch to Spanish when using a "dicho" or "saying," that could lose its meaning if translated into English.

All of the interviewees seem to believe that switching language use can have clinical implications. However, five participants also noted that language use might not hold clinical relevance—perhaps the switching has more to do with language ability and practicality. As one social worker observed about her work with a client, "he just bounces back and forth Spanish to

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English all the time...I don't try to explore that too much because it doesn't seem like it's that therapeutically significant (Participant 7).” Another commented that, “someone...might [switch] for more a practical reason...if he's talking about a tablet or something or talking with his nephew who speaks English, so he might just rephrase the conversation (Participant 5).” Another participant shared that, “if it wasn't specifically trauma related...I'm not sure how much I stopped to think ‘oh they’re switching because of this, that, or the other.’ I think it was more whatever they were comfortable with at the time (Participant 9)...” This fits with the expressed belief that language use may have significance, and it may not—there is an element of uncertainty and of “not knowing” that many participants described.

In general, the social workers interviewed were curious about client language use. Four participants noted that participating in this study increased their curiosity about language dynamics and desire to ask clients about their language use. One clinician said,

I think in general I'm very sensitive to what language the client is choosing to speak... I'm very sensitive in identifying changes in the therapy process or within the therapy session. [This interview] makes me want to analyze it a little bit further, which I obviously do in session, and even address the client when there's particular changes.
(Participant 2)

Another clinician also spoke about the fluidity with which they usually follow clients’ language use. “It is really is interesting for me to try tease this apart. Because I am so fluid and so used to going in English and Spanish all the time they don't really think about it (Participant 7).”

Language and multi-person modalities. Four clinicians discussed client’s language use in family therapy. All of these participants noted that family members often vary in their language abilities, and that this can add complexity to sessions. One clinician noticed that the

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parents she worked with would often use English to join with her, to practice the language, and to communicate with her child in a humorous way. She recounts,

A lot of times the parents will switch to English when they are trying to do reflective listening with their kid in a jokey way. Like the kid is like “whatever” and the mom is like “no whatever. I’m asking you a question in English” and I feel like it’s...this way of being like “don’t pull that American teenage bullshit on me.” (Participant 1)

Participants (n=2) also observed moments of switching when an individual in a family session might want to join with someone in the family.

Social worker’s use of language. All of the social workers interviewed discussed their own use of language in some capacity. The subjects (n=10) talked about “following the clients lead” and using whichever language they use at the time. One clinician observed that, in working with clients from different countries or rural vs. urban areas, she will “make very sure and I try to use their own language and adapt to...what kind of language they’re using (Participant 3).” Similarly, another clinician reflected, “there’s a lot that can be lost in translation if you’re not aware of some specific phrases and the nuances of languages.” With this in mind, the social workers reports that, if she doesn’t know a regionally specific word, she will ask the client what it means and then use the client’s word instead of her word. In reflecting on their language use, three participants also said that they make an effort not to use jargon, as it can be difficult to translate. Instead of jargon, they would find other words for the concepts (such as “trauma” or “cognitive triangle”) and explain to clients.

All social workers talked about their own switching between languages. Two social workers observed that they switch into Spanish when they want to comfort the client. One social worker stated,

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Someone might be like, “I’m so mad about something,” and I’ll be like, “¿Que pasó?” even though we’re speaking in Spanish... I don’t do this all the time, but I think I’m doing it because maybe I’m trying to be more familial with them, like, “Come, tell me what’s going on,” to comfort them in their comforting native language. (Participant 1)

Subjects also discussed switching into Spanish in order to remind clients that they speak Spanish.

As one social worker reports,

I usually like to greet my English-speaking Latino kids in Spanish mostly because I like Spanish greetings. I’ll be like, “Hola amiga. ¿Que pasa?” And then we’ll do the session in English... in a way it’s reminding them at the beginning of the session, like “I got it. If you need to say something in Spanish, I’ll be able to get it,” or “I get that your bicultural even though you’re just going to be speaking in English to me”... I try to make sure there’s a little bit of Spanish in there if they are bilingual... (Participant 1)

Language and trauma narratives

Many (n=8) clinicians interviewed noted that client language choice had implications for trauma treatment. Respondents seemed to pay special attention to language as it relates to client readiness to focus on trauma, trauma narratives, and memory. Four interviewees also discussed language choice as a therapeutic intervention.

Language and assessment for trauma-focused treatment. One participant observed how clients’ language use can help her assess their readiness to discuss trauma in therapy. She states that,

Some people... say that people switch languages to avoid the feelings, and if that’s the case I think it’s a healthy kind [of defense. They] need to keep the defenses because right now it’s not quite the time to get there [to the trauma]. I value that because there are so

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many issues, so I focus on the issues they bring in here. The main thing that I listen for is what it is that with their own psyche is seeking. (Participant 3)

Another clinician notes that she is more careful in assessing multilingual clients than solely English-speaking clients for trauma related disorders. She notes the special usefulness of measures, which she does with everyone, in assessing multilingual individuals, “sometimes having the scales and instruments helps me so that I don't miss it [features of different trauma related disorders]...whereas in English it would be easier for me to figure out because it's my native language... (Participant 6).”

Trauma narratives and memories. When engaging in trauma therapy with multilingual individuals, many clinicians who were interviewed said that they pay more attention to language switching. Five respondents reported that they believe trauma is best processed in the language in which is happened. As one person summarized, “when trauma happens...they can process it better if they can do it in the language in which it happened. That informed my understanding of when people were switching (Participant 9).” Another subject stated that primary language “carries some memories and carries affects and affective memory... (Participant 3).” One clinician spoke of a case in which client language use helped her pace treatment and process trauma:

This client...tends to minimize...she tries to contain her story in some ways and didn't have a lot of coping skills coming in, and again has very complex trauma. She would speak English and it was fine with me. We stuck with English for a while...and the moment that I noticed they [went into Spanish] was when she started speaking of her cousin, who is one of the main perpetrators of the abuse. In speaking about her cousin, I asked her if she could tell me the story about her cousin in the language that it happened,

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which was Spanish. Again, at that point we had a more trusting relationship...I knew that the emotionality might be higher, that was my theory that we went in the Spanish version...[and it happened] because she spoke the words that her cousin used to say to her, and what she thought of herself and how she internalized that... (Participant 2)

Another provider observed that, if the trauma happened early in life, or before the individual learned English, then these experiences “are much more connected to another experiences are much more connected to their mother language and that mother tongue in a primary language (Participant 7).” Similarly, other social workers observed that, if a person’s first language is Spanish, then early trauma is usually expressed in Spanish.

Beyond these linguistic considerations and specific experiences of trauma (ie, related to immigration), three clinicians reported that trauma treatment with multilingual individuals with experiences of immigration to the U.S. was not different from other trauma treatments. As Participant seven reflected,

I really can't say that it's different, except that I can talk with her and I can be with her while she talks about these experiences in Spanish...I really don't think that I'm doing anything differently with her...maybe her experiences are different...[but] I don't think I handled [treatment] differently than I would have if it were it with somebody else...

In a similar spirit, Participant six reflected that “trauma is trauma is trauma,” and that although the content might be different, the process of treatment is not.

Language use as an intervention. In circumstances in which switching seems therapeutically relevant, four social workers described asking clients to use a particular language in order to process trauma. Participant four said that she usually follows the clients lead with language use, unless she thinks that they might be able to access more affect in another language.

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Another therapist describes asking a client to stick with their first language, after noticing that the client's use of English prevented her from feeling too much. The social worker said that,

...There are times I will tell her to just tell me in Spanish because...sometimes [English] pulls her away from the experience. She might start telling me something...painful and it's in Spanish...and then she'll start talking in English and begins to give some distance to the experience and then we don't really get into it is deeply as we might have, or the range of emotion isn't that much there. It's almost like...a barrier, a little bit of a wall that goes up for herself, "I don't really want to go there that much." So then she switches to English. I don't think that's always the case that I do that, but sometimes I do try to press her and say, "I want you to stick with that in stick with it in Spanish." (Participant 7)

On the other hand, participant three emphasized the importance of following the clients' lead and respecting what could be understood as defensive language use.

Language, culture, and race

All of the participants spoke to the importance of cultural competency and humility in engaging in multilingual therapy with individuals who identify as Latino/a and have a history of trauma and immigration to the U.S. Many emphasized the connection between language and culture as well as the uniqueness of each person's experience of immigration and family culture. Some (n=3) clinicians also spoke of racial considerations and dynamics in the therapy relationship.

Immigration and language. All of the social workers interviewed discussed the importance of considering experiences of immigration in therapy with multilingual individuals who identify as Latino/a and have a history of immigration (individual or familial). One clinician

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recalled how language use helped her understand a client's experience of immigration to the U.S. and identity,

I think she's really struggling...she's in between. She's really American, speaking English, wants to go to college, navigating the system as a teen mom, and also culturally feels really connected to other recently recent immigrants. I think she's really in between... She came when she was 12, so she speaks English and her little siblings were born here and they speak English, and other siblings arrived recently and speak Spanish. So even within her own home the siblings have different levels of being Americanized...
(Participant 1)

Many (n=5) participants talked about the importance of paying attention to levels of acculturation, which has implications for language use.

The majority of clinicians also discussed how essential it is to understand people's experiences before immigration, during the journey, and once arriving in the U.S.—as well as where they are in terms of wanting to talk about their experiences. In terms of discussing trauma related to immigration, one social worker observed that, “they don't bring it up unless you ask. It's not like ‘I went through these things that I need to talk about,’ it's like, ‘oh yeah, we all did that’ (Participant 10).” Subjects also mentioned the special importance of considering social identity and things like socioeconomic status, whether an individual is from a rural or urban area, and immigration status.

Culture and language. The majority of clinicians (n=9) emphasized the connections between language and culture. As one subject said,

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For me language and culture are so intertwined... It's impossible to talk about one without the other...and I guess the cultural pieces are really what I think about more than use of language and when one language is used versus the other. (Participant 8)

Most clinicians (n=9) spoke to the importance of cultural humility and curiosity—beyond the ability to speak Spanish. One subject reflected,

I think a lot of people are like “I want to learn Spanish to do therapy because they need bilingual therapists,” and it's more than just learning the language. I think that if people are truly bilingual and they really want to do multilingual therapy, I think that [they need to] familiarize themselves with the culture and a lot of aspects of that culture because [many] have very different experiences... (Participant 7)

Three participants mentioned that religion in particular appears to enter the dialogue more than in sessions with English-speaking American clients. They observed that people were more likely to use phrases like, “God willing,” when discussing the future.

Race and language. Four White social workers discussed worries that they were not the right person to be conducting therapy because of their racial identity. Some (n=3) of these clinicians wondered whether clinicians who identify as bilingual and bicultural would better serve clients. One participant also reflected that,

...Being a white Spanish-speaking clinician, I've thought about how if I were to be ambitious and want to be in a position of higher level with more responsibility, with this population it wouldn't even be ideal. I would rather have someone as of a similar culture and linguistic background of the clientele to be in those positions of leadership.

(Participant 1)

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However, another clinician noted that clients enter therapy with different preferences, "...people at different times look for different things...some people come here and they say, 'I don't want to see another Latina.' They want to see an American person because they just want to be heard by someone who's not bilingual (Participant 3)..."

One participant discussed dynamics of race in the therapy relationship. She spoke of the importance of naming the difference and of being open about the experiences that the therapist has—and doesn't have. She reflected,

...She would say something and I would say, "What was that?" And she would just snap at me like, "You don't speak Spanish do you?"...I had a conversation with her one day that was like, "You know, I'm not going to understand everything right away...it's not ideal but that's the way it is," and she was like "Yeah"...And then one day she said to me, "You know what? Even though you're White, you're okay"...I was like wow, this woman...has probably experienced a lot of racism and injustice and didn't trust me because of my background and then she had a good experience with me and maybe that helped... (Participant 10)

Language and transference and countertransference

In discussing their experiences engaging in therapy with multilingual individuals who identify as Latino/a and have a history of trauma and immigration to the U.S., all of the participants commented on aspects of transference and countertransference. The themes of transference and countertransference relate to language use as well as general feelings about doing therapy with this population.

Transference and language. Participants noted themes of transference related to the social worker's use of language as well as the clients' own language.

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Transference regarding client's use of language learned later in life. Two subjects reflected that some clients seemed embarrassed or afraid of speaking a language learned later in life, in this case English. Participant one observed that some clients spoke English to bond with the social worker, or to show competence by learning to speak the dominant language. Similarly, a social worker observed that clients may feel:

...a pressure to be successful and to know the language of the land and a certain...persona...that they are forced to take upon because they don't want to be embarrassed. They want to be successful...[and] for her specifically I think it was...part of her wanting to show that she is successful in some ways...wanting to show that "I am capable and I know English." It's something that I feel that a lot of the clients feel very pressured to know... (Participant 2)

Transference regarding the social worker's use of language learned later in life. Two social workers commented on transference they noticed regarding the therapists' use of a language learned later in life, which in these cases is Spanish. As described earlier, one clinician noticed anger in response to the social worker's struggle with the Spanish language. Two participants also observed that some clients appeared nervous or anxious when initially speaking Spanish with the social worker. Both of these subjects guessed that the social worker's Spanish might have sounded formal and made it difficult for the client to feel at ease.

Countertransference and language. Participants noted themes of countertransference related to the social worker's own use of language as well as the clients'.

Countertransference regarding the client's use of first language. Three respondents observed that clients appear more "at home" in their first language. One social worker mentioned that, "they [clients] speak much more who they are in their own language...they relax and they

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speak their own language from wherever they are... They don't pretend. They become a real person (Participant 3).” One social worker reflected that, when working with a client from the same country, she uses more slang. “I go there because I know that's where she comes from. Being able to do that creates such intimacy with people. It's just different. ...just me speaking Spanish is not enough (Participant 2).” Two therapists also noted that hearing a trauma narrative in the client's first language is potentially more triggering for the therapist, as the narrative is usually more affect-laden.

Countertransference regarding client's use of language learned later in life. Three social workers reported feeling bored, or that something that missing when the client was speaking in a language learned later in life. One social worker shared that,

There's something missing. They're acting. ...They're saying things...they're describing things, but it's very hard for them to go into their feelings whenever talking in the language that's not quite theirs. Then I get bored because I have a hard time following them because of the accent and also because they're up in their minds. They are telling me what they're doing, they're telling me what they need to be doing, what they ought to be doing and what they ought to be changing... (Participant 3)

One White American clinician also reported feeling frustrated when a client would speak in English (learned later in life) because they forgot that the social worker speaks Spanish. One clinician remembered, “...there was some feeling, almost frustrated—frustrated with myself that...it was unclear...that I speak Spanish (Participant 9).” Other interviewees noticed feeling surprised at the mix of language ability in families.

Countertransference regarding the social worker's use of language learned later in life. Six of the participants reported feeling worried and doubtful about their ability to

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communicate—to understand and be understood—in Spanish, which they learned later in life.

Many (n=6) worried that their non-native language ability would be a barrier to treatment. One social worker said,

...That's my worry: that people aren't getting the competency in their providers that they deserve. ...They should be able to have someone who is completely fluent and able to use their total capacity to be thinking intentionally about interventions and not have like 50% of their headspace trying to think of how to conjugate a verb. Maybe that's exaggerating a little bit because I'm not good at owning the fluency that I do... (Participant 4)

Four clinicians, who have fewer years of experience, reported that this worry about language overlapped with doubts of their competency as newer social workers

Many (n=7) social workers also noted that they feel frustrated with themselves when they can't find a particular word or cannot express themselves in the same way. Many (n=8) clinicians reflected that multilingual therapy takes more energy and preparation than therapy in English only. One interviewee noted, "I have to be completely alert and on my game with clients that speak English and Spanish... (Participant 7)."

General themes of transference and countertransference. In addition to language-based themes, many participants (n=7) mentioned other feelings of transference and countertransference. Two participants noted that clients seemed to have a motherly or confessional transference. Many discussed feeling like clients were "venting." In terms of countertransference, two social workers commented that they sometimes feel "speechless" or amazed at clients' strength and resilience. Three others noticed that it was difficult to sit with and bear witness to certain trauma narratives. Two therapists reflected that it felt rewarding to be someone that a client could confide in and feel that they're helping. Another participant

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remembered feeling “infuriated” at some of the injustices and racism that some clients faced while navigating health and educational systems.

Two clinicians, who identify as immigrants to the U.S., reported feeling that they wanted to use themselves and their experiences of feeling “in-between” cultures and lands to help clients traverse similar territory. As one participant said,

A lot of our immigrants are refugees...people try to integrate and the loss of identity for the second generation, for the kids...the kids are in-between worlds. I think that's really hard to figure out...they're sort of in-between...[and] left country-less in a way...and so when they come, at some point, and are able to sit with someone who is also this in-between thing...I think I can be kind of present and at least be there so they can sort it out for themselves. (Participant 2)

Considerations for language and the agency setting

Participants discussed a variety of challenges while engaging in multilingual therapy in English-dominant agency settings. Many (n=8) discussed the difficulty and loneliness of needing to translate the experience of therapy in team meetings and in agency notes. They also spoke of the difficulty of switching gears, if they have been working in one language more than another. Two participants shared that agencies sometimes have additional expectations for multilingual therapists, and noted a pull to be a translator. One person shared that,

...Because there are so few translators available, providers pressure you to be the translator when that's not your role. You'll be going to a team meeting or an IEP meeting and they're wanting you to translate but...I can't translate and also participate my own insight into the meeting. That's too much and I'm also not supposed to translate. So you get that a lot, and you get a lot of pushback on that and so that's hard. (Participant 10)

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While some receive higher pay, one social worker noticed that multilingual therapists seem to cut back on their hours sooner than their monolingual colleagues, and wonders about higher rates of burnout.

Other social workers (n=4) described bumping up against systemic challenges of access to care and the difficulty of being able to refer clients to culturally competent, Spanish-speaking providers. One clinician said that, “I find myself doing more case management...because I don't think there that there are a lot of other folks out there who are going to look at them holistically... (Participant 7).” Four interviewees also expressed concern about clients' access to therapy due to insurance issues as well as language limitations. As one subject said, “if they don't get the mediocre Spanish then they don't get services at all, which is a sad truth. There is just such a lack of services (Participant 10).” Three participant expressed concern about having only a few clinicians who identify as bicultural and bilingual. One social worker wondered,

It just doesn't make sense to me why recruitment is so hard, at least that's what were told...but I went to school with a lot of bicultural bilingual clinicians and this seems like a very desirable place to work, but maybe there's something I'm not picking up on since we are a majority white staff... (Participant 4)

All participants also identified supports in being able to engage in their work. Half of the participants recalled a specific person, a supervisor or colleague, who encouraged their development as a multilingual social worker. Almost all (n=9) spoke about the importance of consulting with other multilingual colleagues.

Summary

This chapter presents and offers a summary of the findings of 10 interviews with social workers (n=10) who have experience working with multilingual individuals who identify as

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Latino/a, have a history of trauma, and identify as having a history of immigration to the U.S. (personal or familial). Participants were asked a series of 16 questions, as well as follow-up questions. The interview was semi-structured and designed to explore the experiences and perspectives clinicians have engaging in multilingual therapy with an identified population. Clinicians described the experiences in identified areas of: language and treatment; language and trauma narratives; language, culture, and race; language and transference/countertransference; and considerations for language and the agency setting. In the next chapter, the researcher will discuss these findings, their relation to the literature reviewed, and explore implications for social work practice.

CHAPTER V

Discussion and Conclusions

This exploratory, qualitative study aimed to explore experiences of social workers engaging in multilingual—Spanish and English—therapy with individuals who speak both Spanish and English, identify as Latino/a, have a history of trauma, and identify as having a history (personal, familial) of immigration to the U.S. Ten clinical social workers discussed aspects of their experiences engaging in trauma-focused, multilingual therapy through semi-structured interviews. This chapter discusses the findings of those interviews in the following order: 1) key findings, 2) strengths and limitations, and 3) implications and conclusion.

Key findings

The interviews focused on exploring clinicians' experiences engaging in multilingual, trauma-focused therapy. Clinicians were asked questions about things such as: perceptions of role of language, how language may or may not impact treatment, and to reflect on their experiences and observations while engaging in multilingual, trauma-focused therapy with individuals who identify as Latino/a, have histories of trauma and of immigration (personal or familial). Much of what the ten clinicians' discussed in their narratives is reflected in the literature. Examining areas in which the findings and literature do not overlap—for example, layers of the multilingual therapist's role and using language as an intervention—also highlights areas for future research.

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This section will discuss findings that pertain to the following five themes: 1) language and treatment; 2) language and trauma-focused treatment; 3) language, culture, and race; 4) transference and countertransference; and 5) considerations for language and the agency setting.

Language and treatment

Importance of the first language in therapy. Many participants reflected on the importance of doing therapy in the client's first language, which is consistent with the literature. Pérez Foster (1998) and Kokaliari et al. (2013) suggest that it is important to engage multilingual individuals in multilingual treatment. In fact, Pérez Foster (1998) observes that if a client speaks more than one language, it is necessary to work in their native language and other languages they've acquired. Many participants seemed to echo this sentiment of the primacy of language and spoke about how important it is for the clinician to be able to follow the client's lead in terms of languages used.

Some of the participants felt that doing therapy in a client's first language helped clients feel more comfortable. Like Foster (2001), the majority of participants also considered ways that language use can affect multilingual clients' expression of and access to affect, defenses, and general clinical presentation. In this way, both the literature and study also discuss what might be lost—in terms of the client's experience—if the therapy is not conducted in the client's primary language, as well as other languages they've acquired.

Social worker's perception of role. The ways in which participants discussed their perception of their role as multilingual social workers appears to differ from the way it is discussed in the literature. Although the literature review was not exhaustive, studies (Burck, 2002; Kokaliari, 2012; Walsh, 2014; Litjmaer, 2011) suggest that social workers have additional responsibilities when practicing in more than one language. These unique dimensions

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are described including an individual's "different experiences in different languages, the effect of conducting relationships in different languages, issues of finding a liberational voice, and the living of multiple identities" (Burck, 2002, p. 76). Although some participants described doing some of the things Burck (2002) describes, many did not seem to consider it to be unique to their multilingual work. Instead, when discussing their role as multilingual social workers, participants tended to describe their perception of their role as social workers in general; about the value of curiosity, not knowing, and respect in supporting the client meet their identified goal for treatment and understand themselves better.

Walsh (2014) and Burck (2002) suggest that it is important for clinicians to unpack their language issues. The social workers interviewed did not mention this "unpacking" as specific to their role as therapists. However, many participants reflected on the evolution of their relationship to the Spanish and English languages and grappled with language-based countertransference. Many social workers that learned English later in life also reflected on the support they received—from supervisors or peers—when beginning multilingual therapy. When first engaging in multilingual therapy, many reported feeling anxious and questioned their competency. These social workers commented on the value of support in navigating those feelings and to bolster their sense of confidence. It remains to be further explored how social workers engage in critical reflections of multilingual therapy with this population—especially in terms of race and power differentials.

In working with this specific population, many social workers also reflected that they sometimes feel their role to be a "broker" or "translator"—of both communication and of cultural experiences. This aspect—and how clients experience the therapist being a "broker" or "translator"—does not appear to be explored in much detail in the reviewed literature.

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Language and therapeutic alliance. All participants discussed ways that language has an impact on the treatment relationship. Many interviewees suggested that speaking in someone's primary language could be a way to get deeper and strengthen the alliance, and that a clients' shift to their first language from a language learned later in life may signify increased comfort and trust—intimacy—with the clinician. Iannaco (2009), Burck (2002), and Kokaliari (2012) appear to support this notion. Iannaco (2009) suggests that sensitively observing patterns in language switching and the ways a person interacts with the languages can provide insight into individual's psychological state, hopes, dreams, and conflicts (p. 262). More specifically, Burck (2002) observed that switching languages—to a more “familiar” tongue—can connote intimacy. In this case, social workers noticed the ways that switching can indicate a deepening of the therapeutic relationship.

One finding that is not mentioned in the reviewed literature is that, when working with clients who are currently learning English in the U.S., participants who learned Spanish later in life sometimes feel that their shared identity as language learners supports the therapy relationship. These social workers posited that struggling and making mistakes in Spanish could be a useful experience of imperfection, vulnerability, and opportunity to show compassion.

Client's use of language. In contrast to what Pérez Foster (1998) observes about multilingualism, participants did not appear to conceptualize language itself as an organizer of experience. It is possible that participants considered culture as the main organizer of experience, instead of language. Kokaliari (2012) and other studies also recognize the central importance of culture, but seem to hold language in a similar regard (p. 388). Few participants discussed the ways that early object relations and early experiences of attachment and caregiving can be embedded in language, which is frequently discussed in the literature reviewed. However, it's

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possible that this gap is limitation of the study, as the interview did not ask specifically about language and development.

Like much of the literature reviewed, study participants discussed the potential clinical significance of things such as language preference, switching, and emotionality in language may have. Also in congruence with much of the reviewed literature, participants considered factors such as acculturation level and context of language acquisition when considering clients' language use. Interviewees did not refer to their clients' multilingualism as compound and/or coordinate, which could be reflective of the debate in the field over the use and understanding of these concepts. It could also be that these concepts are not widely discussed in social work training programs or continuing education.

Reflecting on individuals' language use, clinicians alluded to the difficulties of native Spanish speakers learning English and/or navigating an English-dominant country. Foster (2001) observes that for some people, to try to express oneself in English is to try to express oneself in the language of those in power—the oppressor. In this sense, language can be the “oppressive other.” The ways that multilingual social workers understand how historic and current oppression—especially in the forms of colonialism/imperialism and globalization—affect clients' use and relation to language remains to be explored.

Regarding clients' language use, the majority of interviewees did not discuss what Marcos et al. (1977) call the “dual self” nor “multiple language-based selves” (Pérez Foster, 1998). However, clinicians who learned additional languages earlier in life discussed their own experiences of living in different worlds based on language. Many described feeling more or less “at home” and in a language. It is possible that personal experience allowed these social workers to be more sensitive to clients' experience of themselves in a particular language.

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Another important finding about client language use is that some expressions, feelings, or memories are untranslatable. Kokaliari et al. (2013) suggests that, “language also operates on the level of associations and meanings that are rarely translatable” (p. 98). Although it doesn’t appear that clinicians were guided by one theory in particular, many reflected that translation was sometimes difficult or impossible. Many cited examples of clients communicating “dichos” or “sayings”—language that could be especially connected to place or culture—or switching.

Language preference. Both the clinicians interviewed and the reviewed literature discuss the importance of client language preference in delivering mental health services. Clinicians appeared to understand language preference in a variety of ways. This includes what Biever et al. (2002) suggest: that individuals who learned Spanish at home or in similar social contexts are usually more comfortable discussing intimate issues in Spanish than English. However, many clinicians also considered things like the therapy relationship (transference and countertransference), past life experiences, acculturation level, trauma history, and mental health issues. As some participants observed, language preference can also be understood as a defense. Specifically, social workers in this study seemed to think that switching can be an indicator of an individual’s readiness or comfort discussing a certain trauma. The literature appears to support this idea, and will be discussed in the context of switching, below.

Switching. Iannaco (2009) supports participants’ claim that it is important to pay attention to switching in sessions. In one study, Iannaco (2009) suggests that sensitively observing patterns in language switching and the ways a person interacts with the languages can provide insight into individual’s psychological state, hopes, dreams, and conflicts (p. 262). Many social workers were sensitive to tracking shifts and differential language use.

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Some participants also observed that switching is not always clinically significant—that there is an element of the unknown when it comes to switching and what it means. Significantly, many participants reported paying more attention to language switching when engaging in trauma-focused therapy. This is likely because, as Pérez Foster (1998) and participants discuss, switching can hold information about “psychic defenses, as a mechanism of repression, as a neutralizer of early desires, and a symbolic signifier of internalized self-representations” (p. 105). Switching can be an effective way to approach or distance affect and memories.

Like Kokaliari et al. (2013), participants discussed swearing as a common moment of switching. They also found that individuals found it more satisfying to swear in one’s primary language. However, participant noticed different patterns, which suggests that clients swear in the clinician’s primary language—perhaps to help the clinician feel the strong emotion they’re feeling. Kokaliari et. al. (2013) posit that swearing in one’s non-native language could also be due to other factors, such as swearing being connected to a lower social class.

Social worker’s use of language. With regards to participants’ own language use, many noted that they felt more curious about their switching during the interview. Many participants described their language use—including switching—as automatic and second nature. These social workers were curious to tease this apart and better understand what informs their language use. They were also curious about the potential usefulness of discussing switching with clients.

Some social workers identified patterns in their own switching. Many noted that they shift along with clients, moving to and fro in whichever language clients choose. Another emergent pattern was of switching to Spanish to try to comfort or connect with clients. This might be due to what Pérez Foster (1998), Kokaliari (2012), Kokaliari et al. (2013), and others observe, which is that language is encoded with the tone of early caregiving. Perhaps clinicians

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switched to Spanish when they felt a sort of parental countertransference, or pull to comfort in a particular way. Some also noticed that they switch in order to remind clients that they speak Spanish—especially if most of the therapy is happening in English. Others discussed switching language as a type of intervention, which will be discussed later in this chapter. Overall, further exploration of patterns of language use and how clients respond to ways clinicians use language appears necessary.

Language and trauma treatment

As discussed above, both the participants and the literature reviewed discuss the importance of noticing and attending to differential language use in multilingual trauma therapy. This section will examine what the study and literature observe about 1) language and assessment for trauma-focused treatment, 2) trauma narratives and memories, and 3) language as an intervention.

Language and assessment for trauma-focused treatment. In congruence with Pérez Foster (1998), participants discussed the impact of language on assessment for treatment. In this study, social workers specifically discussed ways that language impacts trauma-focused treatment. Clinicians noted that individuals' clinical presentations could vary depending on language. To account for possible differing language-based presentations as well as social workers' competence assessing in a second language, some social workers appeared more careful in their assessments. Some incorporated measures—specific to trauma-related disorders—to aid the process.

When clients speak in a language other than their primary language, Foster (2001) and interviewees sometimes observed detached affect. This likely has implications for how much an individual can integrate the experience and emotion. Participants understood this as both an

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adaptive and, after time a possibly maladaptive, defense. Therapists seemed to use this linguistic information to assess client's readiness to engage in trauma-focused therapy and pace treatment.

Trauma narratives and memories. Another major finding is that the many therapists interviewed reported that trauma is best processed in the language in which it happened. A study by Javier (1993) supports this finding. The study holds that memories are best recalled in the language in which they happened. This language matching—of life experience and recall—allows people to express memories with greater detail, vividness, and affect, which can aid the therapy.

Of course, many people do not have clear memories of the trauma, and narratives are fragmented—no matter which language they're in. Many social workers commented on that, and their role in helping clients form a more cohesive narrative, or to somehow integrate the experience verbally, through EMDR, or art therapy. Social workers that utilized these less verbal, less narrative-focused models seemed to emphasize the universality of trauma and healing. Perhaps they focused on this and appeared less focused on understanding the layers of language due to the nature of the therapy. It would be interesting to further explore how a social worker's theoretical orientation impacts dynamics in multilingual therapy.

Some clinicians spoke of client empowerment and elements of narrative therapy in trauma therapy and its role in healing. Yet, the role language plays in empowerment remains to be further explored. Burck (2002) observes that using a particular language to recall trauma can “challenge atrocity by reclaiming language” (p. 78).

Unlike Kokaliari (2012) and Kokaliari et al. (2013), few clinicians interviewed discussed that communicating a narrative—trauma or otherwise—may take extra energy and simplify complex experiences (p. 99). Some participants did, however, note the loss that can be involved

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if a multilingual client engages in therapy only in a language learned later in life. This could be due to a simplification or modification of experience necessitated by language ability and/or connection to affect and affectively-charged memories.

Language use as an intervention. Almost half of the participants described using language as an intervention. Although all social workers valued “following the clients’ lead” with language use, some cited moments in which they asked a client to stick with or switch to another language. The intervention was meant to help clients stay with or approach difficult affect, and was based off of clinicians’ observations of the client’s switching and language use. Similarly, in a multi-person modality, one therapist described designing a language-specific, art-based intervention. This intervention was meant to center a primarily English-speaking family member, while encouraging a primarily Spanish-speaking parent to bear witness to but not actively participate in the process.

Kokaliari et al. (2013) also found that some therapists encouraged clients to go into their primary language to help process trauma memories. However, this occurred in dyads in which the therapist did not speak the clients’ primary language. Kokaliari et al. (2013) reflect that this was potentially dangerous, as the clinician was not aware of what clients were saying—clients might be at risk for flooding or disorganization without the therapist knowing. Since participants and clients in this study speak Spanish and English, the language intervention that they describe has a different quality.

Although these interventions are discussed as being helpful, there remain questions about potentially negative effects of directive, language-specific interventions. It could be interesting to talk more in depth with therapists about how it impacts the relationship. Overall, it appears that

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there has not been enough research around language interventions and power differentials regarding use of directive language interventions.

Language, culture, and race

Like Falicov (2014), most social workers interviewed hold that immigration is not a pathological event. In working with individuals who have history of trauma and immigration to the U.S., most interviewees reflected on the potential stressors and possibly traumatic aspects of immigration. Few participants discussed problematic policies and systems related to immigration to the U.S.—attitudes about which have implications for treatment. As Park et al. (2011) advocates, research about the attitudes of U.S. social workers toward immigration and immigrants is urgently needed and essential for ethical and appropriate services to these populations.

Unlike Falicov (2014), clinicians did not discuss the possible benefits of a migration narrative as a way to understand the meanings of migration events and relational stressors that may have followed (p. 102). It is possible, though, that some social workers included the idea of a migration narrative with trauma-informed therapy in general. Many spoke of seeking to understand a client's unique experience of immigration and where they are in terms of wanting to process it, much like Foster (2001).

In discussing experiences of immigration, Eng and Han (2000) discuss that idea that melancholic loss and racial melancholia are part of the fabric of assimilation, immigration, and radicalization within the sociocultural context of the U.S. While many participants were mindful of the losses involved in immigration, in the narratives, few explicitly discussed experiences of oppression and racism—histories and experiences of being “raced” in the U.S.—that an individual might have, nor how racial identity could affect the therapy relationship. This could be

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due to the emphasis that many clinicians put on culture versus race. I am also curious about whether issues of race, racism, and power differentials would have surfaced more if the study had included more clinicians that identify racially as something other than White. I am curious to further explore dynamics, attitudes, and practices about ways multilingual social workers engage in conversations about race, racism, and oppression with Latino/a clients with histories of immigration to the U.S. As Kokaliari (2012) observes, clinicians “should be aware of their own ethnic identities, values, and conceptions of self and other, and they should be aware of how histories of countries are often played out in the treatment process. They should also attend to the power dynamics that will inevitably emerge...” (p. 393).

Participants emphasized the connections between language and culture. Respondents discussed the value of cultural competence and humility. Kokaliari et al. (2013) supports this finding as an important aspect of multilingual therapy. Many participants recognized this stance of humility and curiosity as central to their role as social workers.

In terms of how immigration impacts language use in therapy, many participants discussed acculturation level. This, some suggested, can affect their relationship to speaking English in an English-dominant society. Foster (2001) discusses one such relationship, which she calls “second-language anxiety” (p. 164). This anxiety, she suggests, centers around being perceived as “passive, inarticulate, simple-minded, or unsophisticated in a second-language, which one knows is not expressing the full compliment of one’s thoughts and feelings” (Pérez Foster, 2001, p. 164). Some clinicians interviewed observed a similar anxiety, which will be discussed in more detail below.

Transference and countertransference

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In the narratives, respondents discussed various themes of transference and countertransference, both related to language and to treatment in general. As Litjmaer (2011) suggests, it also appears in the study that different possibilities for transference and countertransference exist when therapy happens in more than one language. It is possible that the language-specific focus of the study (multilingual Spanish-English therapy dyads) seems to have opened space for social workers to talk more in depth about specific language-based themes, compared to other studies, which note more general themes.

Transference. Participants observed individuals express anxiety or worry about speaking a language learned later in life. They noticed that clients sometimes felt pressure to speak English (to show capability). They also noticed that clients whose first language was Spanish sometimes accommodate, and other times express anger in response to non-native Spanish-speaking social workers' struggle with the language. This transference, which Kokaliari et al. (2013) describe as hostile, could be related to worry that a white, non-native Spanish-speaking social worker will not understand them.

Unlike the literature, clinicians noted that clients sometimes appeared nervous or anxious when speaking Spanish with the social worker. One participant suggested that the anxiety could be due to the formality of the social worker's Spanish. More research is likely necessary to understand this language-based transference, and what role factors like power and privilege may play—as well as social worker level of language fluency/ability. Also unlike the literature, many clinicians noticed a “confessional” or venting transference. Clinicians understood this by looking at a client's conception of therapy—often understood in terms of cultural practices and norms—as well as considering power differentials.

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Countertransference. Many interviewees noticed anxiety within themselves related to their use of a language learned later in life. This appears connected to the wish to show competency or to prove ones linguistic ability that Kokaliari et al. (2013) and Litjmaer (2011) discuss. Also connected to this anxiety is the frustration that some clinicians described when their linguistic competency faltered.

Some clinicians who identify as white also reported sometimes feeling uncomfortable in their role. Some wondered whether a therapist who identifies as bilingual and bicultural would better serve clients from this population. Participants who learned Spanish later in life identified what could be described as an ethical dilemma about providing therapy in Spanish. They described this as a tension between providing therapy in Spanish—which they sometimes do not feel as competent in, but is in high demand—and the client receiving no therapy at all. It appears that some clinicians resolve their anxiety about providing multilingual therapy by reasoning that, if they don't, clients will go without services.

It seems that more research is needed to understand how social workers can be supported in delivering ethical and appropriate services to multilingual—and monolingual, for that matter—populations. It seems uncommon for agencies to assess and support clinician language capabilities (Engstrom et al., 2009), the presence of which might help multilingual clinicians feel—and be—more effective and competent. Additional support from policies and agencies might also help clinicians feel less anxious about their language abilities.

Like the literature, respondents also noted that clients often appear more relaxed and “at home” in their primary language. In fact, some clinicians noticed that they feel bored if a client who is not fluent in English speaks in English—something not mentioned in the literature. Although the literature does not discuss this, participants importantly noticed that engaging in

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trauma therapy in the client's native language can be more triggering for the clinician. It could be valuable to explore this more and how it relates to switching and trauma treatment in general.

In instances when the clinician and client share a cultural or racial identity, clinicians described feeling more familiar—some noticed that they use more slang. Surprisingly, few clinicians talked explicitly about a fear of over-joining with clients. Kokaliari (2012) cites a fear of over-joining as common countertransference, which can lead to avoidance of some issues. It is possible that this countertransference wasn't as commonly discussed due because most of the clinicians interviewed identify as white and working cross-racially and cross-culturally and are less likely to experience over-joining.

Considerations for language and the agency setting

Participants describe challenges for multilingual social workers in the agency setting similar to challenges Engstrom et al. (2009) note. Subjects discussed challenges related to larger caseloads, extra responsibilities—especially pressures to translate, as well as feeling that multilingual cases require more energy. In addition to this, some participants discussed feeling lonely in English-dominant agencies, and encumbered by extra layer of translating the entire therapy experience (for paperwork, in consultations).

Social workers were also curious whether burn-out rates are higher for multilingual clinicians, as well as why it appears difficult for some agencies to hire clinicians who identify as bilingual and bicultural. Taking this into account, some participants expressed concern about how individuals from this particular population can access services. It would be interesting to explore ways agencies could better support multilingual therapists deliver multilingual services. Currently, it seems that there is a high demand for multilingual providers and more research is necessary to better understand how to support these social workers. However, many participants

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worked within outpatient/community-based mental health settings and it is possible that multilingual social workers are more supported in different settings.

Strengths and limitations of this study

The researcher conducted a qualitative, exploratory study to answer this research question: What are the experiences of clinicians in processing trauma with Latino/a immigrant populations in the U.S. in two languages—Spanish and English? I developed a flexible study, which aimed to deepen our understanding of the phenomenon without formal assumptions about relationships between language, trauma, and immigration.

One advantage of conducting this investigation as an exploratory qualitative study is that it opened rather than limited the things that participants could share. This openness helped the researcher gain a better understanding of their experiences. Many participants also shared that the process of the interview helped them reflect on and be curious about their work. The nature of the exploratory qualitative study also serves to document actual experiences and voices of multilingual social workers, which have been lacking in the literature on the topic.

Due to its subjective nature, an exploratory qualitative study also has limitations. As the sole researcher, I made every effort to approach interviews with an awareness of my own perceptions and beliefs. However, the fact that I identify as a bilingual, multi ethnic/racial, Latina, female likely impacted the way I conceptualized and engaged with this study. These factors and other aspects of my social identity and perspective likely impacted the way I understand and interpret participant responses.

Another notable limitation is the small sample size (n=10), racial and gender homogeneity (10 of the clinicians identified as white, one identified as Latina; all identified as female), and geographic location of practice (all based in Massachusetts). This significantly

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limits the generalizability of the study. It's possible that the racial homogeneity of the study is a reflection of the field of social work, and the way that institutional racism in the U.S. currently and historically functions, for example, to limit access to education/resources necessary to attain a master's degree and license in social work. A larger sample would also help improve data reliability and validity. However, the sample did represent a range in years in practice, which may have helped the study better encompass the different experiences social workers have with multilingual therapy throughout their professional lives.

The language I used to recruit participants might have been another limitation. When I initially distributed information about my study, I was met with some confusion about whether the focus was on monolingual or bilingual clients. I chose to use "multilingual" so as not to assume/limit participation to those who speak only two languages. I revised my outreach materials to clarify this. Despite this additional clarification, some participants talked about monolingual Spanish-speakers as well as bilingual/multilingual. It could have been interesting to discuss this more with participants, as well as explore possible bias that newly arrived/first generation immigrants to the U.S. will be monolingual.

Another limitation could be that the research study was conducted in English. I am curious about how this language choice might have reflected certain dynamics of multilingual therapy—especially as it centered the English language as primary. In retrospect, I would like to have given participants the choice of which language to use. It could be interesting to note language use in the interview itself, as well.

As flexible methods dictate, I developed an interview guide with semi structured, open-ended questions. In retrospect, I might have made questions slightly less open-ended. While I wanted to open space for social workers to discuss any aspect of their experience, it is unclear

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whether social workers did not discuss certain topics because they were not placed on their radar. It is also possible that some participants experienced the open-ended questions as overwhelming, which would affect their responses.

Implications and conclusion

This study gives voice to experiences of some multilingual social workers engaging in multilingual—Spanish and English—therapy with individuals who speak both Spanish and English, identify as Latino/a, have a history of trauma, and identify as having a history (personal, familial) of immigration to the U.S. It observed and collected narrative data related to the ways clinical social workers think about language, navigate issues of transference and countertransference, and conceptualize their use of self in the context of this particular therapeutic dyad.

The results of this study have implications for service delivery to vulnerable and oppressed populations. Results and reflections on the process of the study also point to directions of future study. Specifically, it appears that future research could be conducted to further explore dynamics, attitudes, and practices about ways multilingual social workers engage in conversations about race, racism, and oppression with Latino/a clients with histories of immigration to the U.S., as well as attitudes about immigration and immigrants. For the most part, this study focused on individual treatment modalities. A future area of study, then, could be multi-person multilingual therapy—perhaps specifically in family therapy. I also recommend further research into ways that social workers could be better supported in multilingual therapy in clinical settings and through continuing education. As the sample of this study was limited by sample size and homogeneity, I also suggest conducting a similar study with greater diversity and number of participants.

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Appendix A

Interview Questions

Demographic questions

Gender F [] M [] T []

What is your degree and licensure? LCSW _____ LICSW _____ MSW _____ PhD _____

How many years of experience do you have doing therapy?

1-5 [] 6-10 [] 11-15 [] 16-20 [] 21 < []

How many years of experience do you have doing multilingual therapy?

1-5 [] 6-10 [] 11-15 [] 16-20 [] 21 < []

How many multilingual clients do you see per week?

1-5 [] 6-10 [] 11-15 [] 16-20 [] 21 < []

How many multilingual clients with histories of trauma do you see per week?

1-5 [] 6-10 [] 11-15 [] 16-20 [] 21 < []

How many multilingual clients who identify as Latino/a immigrants to the U.S. and have histories of trauma do you see per week?

1-5 [] 6-10 [] 11-15 [] 16-20 [] 21 < []

Do you identify as one of the following?

White/ Caucasian _____ Hispanic or Latina _____ Asian/Pacific Islander _____
American Indian _____ African American/ Black _____ Biracial _____ Other ____ (specify)

How would you describe your cultural background?

Do you identify as a first, second, third, or fourth generation immigrant the U.S.?

In which languages do you practice therapy?

Opening questions

I was wondering if you could tell me what motivated you to be interviewed.

How did you come to work with multilingual clients? And immigrant populations?

Role of clinician and language

Before we get further into this interview, I'm wondering about your first impressions of the role of language in therapy? As a multilingual clinician?

How do you think about your role as a clinician who practices therapy in Spanish and English?

What can you tell me about the role of language in multilingual therapy? What have your experiences been?

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Immigration and language

What sorts of things do you consider when working in Spanish and English with clients who have immigrated to the U.S.? Can you provide any case examples?

How do you think about your clients' language use?

In your experience, what have you noticed about your multilingual clients' use of language?

Dynamics of Therapy

How do you think about language choice in terms of the therapeutic alliance? And how about the way that language choice affects the therapy?

Is there anything you notice about the moments when a multilingual client changes from one language to another? How do you understand these shifts?

Multilingualism and Trauma

What sorts of things do you consider when working in more than one language with clients who have a trauma history? Can you provide any case examples?

What are your experiences with clients expressing trauma experiences in more than one language and/or a second language? Can you provide any case examples?

Can you tell me about a case that highlights the role of language in therapy with a multilingual Latino/a immigrant client who has a history of trauma?

Closing questions

What sorts of challenges do you face as a multilingual therapist?

Is there any advice you would give to other clinicians about engaging in multilingual psychotherapy with Latino/a immigrant populations?

Is there anything you'd like to add that you feel is important to this subject?

Thank you!

Appendix B

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

.....

Title of Study: Experiences of multilingual social workers: Trauma work in Spanish and English
Investigator: Emily Avilés, [REDACTED]

.....

Introduction

- You are being asked to be in a research study about social workers’ experiences engaging in multilingual therapy with individuals who have histories of trauma and immigration.
- You were selected as a possible participant because you are currently a licensed social worker in the U.S. who has experience engaging in therapy with clients who speak both Spanish and English, identify as Latino/a, have a history of trauma, and identify as having a history (personal, familial) of immigration to the U.S.
- We ask that you 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 gain insight into social workers’ experiences engaging multilingual therapy with individuals who have histories of trauma and immigration. The study aims to gain a deeper understanding of the nuances of trauma work with clients who identify as multilingual as well as Latino/a immigrants to the U.S.
- I am conducting this study as my master’s thesis, and it is part of a research requirement for my master’s in social work degree.
- Ultimately, this research may be published or presented at professional conferences.

Description of the Study Procedures

- If you agree to be in this study, you will be asked to do the following things: To be interviewed by the researcher for about one hour about your experiences working with individuals who have a history of trauma and identify as Latino/a immigrants to the U.S.—in Spanish and English. The interview will be audio recorded.

Risks/Discomforts of Being in this Study

- While the study has little foreseeable risk, you have the right to decline to answer my question, or end the interview early if the discussion causes you discomfort.

Benefits of Being in the Study

- The benefits of participation are: supporting a reflective clinical practice by participating in a space for clinicians to reflect on their work, possible satisfaction knowing that their experiences may contribute to further research to support clinical practices.

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- The benefits to social work/society are: Enhanced understanding of clinicians' experiences of processing trauma in two languages may support the development of ethical and appropriate services to marginalized newcomers, contribute more information about how to provide high quality services for multilingual individuals and immigrant populations.

Confidentiality

- Your participation will be kept confidential. The researcher will be the only person who will know about your participation. The interview will be held at either the researcher's office, your office, or at a quiet, public place that allows for privacy. If the interview will be held via video conference, every effort will be made to ensure that both the interviewer and participant are in private spaces. Additionally, the records of this study will be kept confidential. The researcher will be the only one who will have access to the audio recording, with the exception of a potential transcriber, who will sign a confidentiality agreement. Audio recording digital files will be password protected and permanently deleted from the recording device. Recordings will be destroyed after the mandated three years.
- All research materials including recordings, transcriptions, analyses and consent/assent documents 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, as well as to withdraw completely up to the point noted below. If you choose to withdraw, I will not use any of your information collected for this study. You must notify me of your decision to withdraw by email or phone by April 1, 2015. After that date, your information will be part of the thesis.

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, at any time feel free to contact me, Emily Avilés at [REDACTED] or by telephone at [REDACTED]. If you would like a summary of the study results, one 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.

EXPERIENCES OF MULTILINGUAL SOCIAL WORKERS: TRAUMA THERAPY IN SPANISH AND ENGLISH

Consent

- Your signature below 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. You will be given a signed and dated copy of this form to keep.

.....

Name of Participant (print): _____

Signature of Participant: _____ Date: _____

Signature of Researcher(s): _____ Date: _____

.....

1. I agree to be audio taped for this interview:

Name of Participant (print): _____

Signature of Participant: _____ Date: _____

Signature of Researcher: _____ Date: _____

2. I agree to be interviewed, but I do not want the interview to be taped:

Name of Participant (print): _____

Signature of Participant: _____ Date: _____

Signature of Researcher: _____ Date: _____

EXPERIENCES OF MULTILINGUAL SOCIAL WORKERS: TRAUMA THERAPY IN SPANISH AND ENGLISH

Form updated 9/25/13

Appendix C

Hello,

My name is Emily Avilés and I'm a graduate student at Smith College School for Social Work. I'm currently conducting a study as part of my Master's thesis and am hoping that you may be interested in participating.

A little bit about my study: I'm interested in understanding more about the nuances of trauma work with clients who identify as multilingual as well as Latino/a immigrants to the U.S. While there is research about how multilingualism may impact therapy, there are not many studies that focus on the intersections between multilingualism and trauma therapy.

To this end, I'm hoping to talk with 12-15 licensed clinical social workers who have experience working multilingually—in both Spanish and English—with individuals who identify as Latino/a immigrants in the U.S. and who have histories of trauma.

I'm interested in speaking with social workers who:

- Are currently licensed as social workers in the U.S.
- Speak and practice therapy with clients in both Spanish and English
- Have experience engaging in therapy with clients who speak both Spanish and English, identify as Latino/a, have a history of trauma, and identify as having a history (personal, familial) of immigration to the U.S.

Interviews will go for about one hour, and can be conducted in person in the Greater Boston Area or via video conference. Your participation will be confidential.

If you are interested in participating or have any questions, please contact me at [REDACTED] or [REDACTED].

Even if you do not meet the criteria to participate, you could make an important contribution to my study by kindly forwarding this email to those who either may be interested in participating themselves and/or have a network they might forward this email to. With permission, I would be happy to contact any potential participant.

With gratitude,
Emily Avilés

Appendix D

Calling social workers who work in Spanish and English

Are you a licensed social worker in the U.S.?

Do you work and practice therapy in both Spanish and English?

Do you have experience engaging in therapy with clients who speak both Spanish and English, identify as Latino/a, have a history of trauma, and identify as having a history (personal, familial) of immigration to the U.S.?

Are you interested in sharing your experiences?

If you answered “yes” to these questions, I’d love to hear from you! I’m a graduate student at Smith College School for Social Work and currently conducting a study as part of my Master’s thesis.

This study aims to better understand the nuances of trauma work with clients who identify as multilingual as well as Latino/a immigrants to the U.S. While there is research about how multilingualism may impact therapy, there are not many studies that focus on the intersections between multilingualism and trauma therapy.

To this end, I’m hoping to talk with licensed clinical social workers who have experience working multilingually—in both Spanish and English—with individuals who identify as Latino/a immigrants in the U.S. and who have histories of trauma

Interviews will go for about one hour, and can be conducted in person in the Greater Boston Area or via video conference. Your participation will be confidential.

If you are interested in sharing your experiences and/or know someone who might be, please contact: **Emily Avilés** at [REDACTED] or [REDACTED]

EXPERIENCES OF MULTILINGUAL SOCIAL WORKERS: TRAUMA THERAPY IN
SPANISH AND ENGLISH

Appendix E



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

February 12, 2015

Emily Aviles

Dear Emily,

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: Jennifer Harrison, Research Advisor

EXPERIENCES OF MULTILINGUAL SOCIAL WORKERS: TRAUMA THERAPY IN
SPANISH AND ENGLISH

EXPERIENCES OF MULTILINGUAL SOCIAL WORKERS: TRAUMA THERAPY IN
SPANISH AND ENGLISH

Appendix F



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

March 6, 2015

Emily Aviles

Dear Emily,

I have reviewed your amendments and they look fine. These amendments to your study are therefore approved. Thank you and best of luck with your project.

Sincerely,

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

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

CC: Jennifer Harrison, Research Advisor