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Therapists' Perceived Influence of Language: Second Language Spanish Speaking Therapists with Native Spanish-Speaking Clients

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Therapists’ Perceived Influence of Language:
Second-Language Spanish-Speaking Therapists with Native Spanish-Speaking Clients

By
Cameron D. Mount

A thesis submitted to the faculty of
Brigham Young University
In partial fulfillment of the requirements for the degree of
Master of Science

Marriage and Family Therapy Program
School of Family Life
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GRADUATE COMMITTEE APPROVAL

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ABSTRACT

THERAPISTS’ PERCEIVED INFLUENCE OF LANGUAGE: SECOND-LANGUAGE SPANISH-SPEAKING THERAPISTS WITH NATIVE SPANISH-SPEAKING CLIENTS

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Experiences of the bilingual client in therapy have received attention in the literature but accounts of the experience of the bilingual therapist are strikingly sparse. The purpose of this study was to focus on the bilingual therapist’s perception of the impact of language on the therapeutic process. To achieve this goal, the researcher interviewed therapists who speak Spanish as a second language and work with native Spanish-speaking clients. Data analysis was completed using ethnographic research methods, which resulted in the emergence of three themes. The first theme included therapists’ perceived obstacles to second-language therapy. Each of the participants in the study discussed things that made therapy in a second language more difficult for them than in their native English.
The second theme that emerged included the compensatory coping strategies. Many of the therapists interviewed discussed certain strategies they employed to prepare themselves to offer competent services to the Spanish-speaking community. These coping skills compensated for the obstacles that were unavoidable in their second-language work. The third and final theme included the facilitative beliefs about Spanish-language work experience. Each of the therapists interviewed for this study expressed certain beliefs that enabled them to continue offering services in Spanish in the face of some intense difficulties. These beliefs gave therapists a positive spin on their experiences, and enhanced their beliefs that doing therapy in Spanish was worth the added effort it took to do therapy in a second language. Implications for clinicians as well as future research are presented.
ACKNOWLEDGEMENTS

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CHAPTER I: INTRODUCTION

In the past several years, immigration of Latinos from South and Central America into the United States has been steadily increasing. In 2004 it was estimated that over 40 million Latinos were currently in residence in the United States (U.S. Census Bureau, 2004). More than 12 percent of people living in the United States speak Spanish in their home (U.S. Census Bureau, 2004). It is estimated that in 40 years, one in four people in the United States will be Latino (Zavala, 1999).

The Latino population’s access to mental health services for the Latino population is a major health concern. Many Latinos are confronted with such factors as the language barrier, poverty, and discrimination in education and employment, resulting in disorders related to depression, stress, and adjustment (Padilla, Ruiz, & Alvarez, 1989). Because of the rapidly changing demographic landscape of the United States, mental health professionals are under pressure to provide culturally and linguistically relevant treatments to their Latino clients (Altarriba & Santiago-Rivera, 1994).

Multi-cultural therapy has seen a deserved increase in attention in the professional literature during the past several years in response to the recent increase in immigration of the Latino population. In an early review, Pedersen (1976) indicated, “each cultural group requires a different set of skills, unique areas of emphasis, and specific insights for effective counseling to occur” (p. 26). As researchers began to include more diverse minority populations as the foci of their studies, it became increasingly apparent that the treatments originally developed in the United States were most helpful to a primarily upper class, White clientele. Pedersen noted that such services were inappropriate for other groups, even those within the same cultural context.
Latino clients experience therapy differently than do non-Hispanic clients. When compared to control groups, Latino clients underutilize mental health services and tend to terminate treatment prematurely (Acosta & Cristo, 1980). Padilla et al. (1989) believe this is due to unfamiliarity with the overall functioning and role of the mental health system. Furthermore, these researchers contend that Latino clients often received less attention, may be required to use English, and are treated with insensitivity and a lack of understanding on the part of the clinicians (Padilla et al., 1989). Such clinical obstacles undoubtedly yield a unique and potentially problematic experience in therapy for Latino clients.

One of the major complications inherent in therapy with Latino clients is the language barrier. Latino clients whose dominant language is Spanish may focus more on pronouncing words and phrases correctly in English than on expressing themselves (Marcos & Urcuyo, 1979). These researchers further noted that bilingual clients speaking in their second language did not always show the appropriate affect when speaking about emotionally charged topics or experiences. The use of a non-dominant language can have a distancing effect from the emotional content of a given situation. Marcos and Urcuyo (1979) wrote that patients speaking in their second language displace their affect toward the more difficult verbalization process. “The patient may, then, verbalize emotionally charged material without displaying the appropriate emotion. This diminution in the affective tone may be responsible for experiences to be felt as vague and unreal by both the patient and the therapist” (p. 332). Sue (1990) noted that other vocal cues such as tone, rate, and inflection could also be misinterpreted when clients communicated in their non-dominant language.
Experiences of the bilingual client in therapy have received attention in the literature but accounts of the experience of the bilingual therapist are strikingly sparse. Biever et al. (2002) note that, “little is available to assist bilingual practitioners in providing services in Spanish” (p. 330). Therapists working in a second language might also have difficulty expressing emotion, which could have negative effects on the therapeutic alliance, which is one of the most powerful predictors of therapeutic outcome (Henry & Strupp, 1994; Horvath & Bedi, 2002; Horvath & Symonds, 1991; Martin, Garske, & Davis, 2000).

Many therapists express decreased confidence in their Spanish language work (Sprowls, 2002). Therapists working in Spanish as their second language perceive many differences in their experience of therapy in comparison to their English-language work, including struggling with a limited vocabulary (Biever et. al., 2002), and an increase in casual, chatty conversation in Spanish (Clauss, 1998). When working in a non-dominant language, a therapist can have increased feelings of insecurity, inferiority, and estrangement (Kitron, 1992).

Furthermore, the bilingual therapists who do therapy may present treatment in a more compact, direct method, and rely more on nonverbal cues to communicate the emotional content of their language. This ability to communicate subtle emotional cues to clients is an important aspect of therapy.

Purpose of this Study

The purpose of this study was to focus on the bilingual therapist’s perception of the impact of language on the therapeutic process. More specifically, two goals were
identified for the qualitative interviews with regard to therapists’ experiences in doing therapy in Spanish.

1. Determine if there were common difficulties, rewards, and skills which were developed to compensate for the problems inherent in this type of therapy.

2. Determine if therapists had shared beliefs about the therapeutic experience of doing therapy in Spanish and English.

Review of Literature
The following review of literature focused on therapists working in Spanish as their second language with native speaking clients, as well as the language aspect of treatment and its relationship to three therapeutic areas including (a) the therapeutic alliance, (b) working with emotions, and (c) the quality of treatment.

The Importance of Multicultural Considerations
Multicultural issues were reviewed briefly. Although it was not a major focus of this study, cultural considerations influence the way language is used. Various subtle cultural nuances may be missed. Use of language often conveys shades of meaning or feeling. These may be critical in therapeutic experiences. Various cultures pose specific problems for the therapist and may be subtly or explicitly difficult for the therapist to handle; however, this study focused primarily on the language itself.

The multicultural aspect of therapy has received increased attention in the recent past. As populations continue to become more culturally diverse, mental health professionals have pressed forward to understand how to provide better and more appropriate services to the culturally different. Sue and Sue (2003) wrote that “counseling and psychotherapy have done great harm to culturally diverse groups by
invalidating their life experiences, by defining their cultural values or differences as deviant and pathological, by denying them culturally appropriate care, and by imposing the values of a dominant culture upon them” (p. 8). These multicultural dilemmas are further complicated when either the client or the therapist must translate them into a secondary language. The preparation of culturally competent clinicians has become an integral component of the core competencies of the American Association of Marriage and Family Therapists because mental health resources under-serve these groups (AAMFT website, 2005).

Patterson (1996) argues that there are several problematic aspects of the multicultural counseling movement. One problem he highlights is the preference of clients from other cultures for an active, authoritative, directive, controlling counselor, which has been shown to be a desire of several minority groups that present for therapy (Sue & Sue, 2003; Sue & Morishima, 1982; Szapocznik, Sanisteban, Kurtines, Hervis, & Spencer, 1982; Vontress, 1976, 1981). Many ethnic minority clients tend to be less comfortable with self disclosure in therapy (Patterson, 1996). Therapists who slip into the role of the authoritarian therapist will, in the process, may deny their client one of the most integral and important aspects of the therapeutic relationship. Patterson (1996) concluded, “it now appears that this preoccupation with techniques is fading and that it is being recognized that counselor competence inheres in the personal qualities of the counselor. The competent counselor is one who provides an effective therapeutic relationship. The nature of this relationship has long been known and is the same regardless of the group to which the client belongs” (p. 229).
Again, language discomfort or inadequacies make the bilingual therapist’s task of relating in a genuine and authentic way more difficult because of the nuances and subtleties of the language. Language plays an undeniable role in the formation and maintenance of the therapeutic alliance.

**Alliance**

The therapeutic alliance has long been valued as an integral component of successful mental health care delivery (Gelso & Carter, 1985; Marziali & Alexander, 1991; Sexton & Whiston, 1991). Reviews of the individual therapy research literature (Henry & Strupp, 1994; Horvath & Bedi, 2002; Horvath & Symonds, 1991; Martin et al., 2000) have repeatedly concluded that the alliance is directly related to favorable therapy outcome. In their review of family therapy vocabulary, Simon, Stierlin, and Wynne (1985) indicate that the terms alliance, alignment, and coalition refer to “the perception or experience that two or more persons are joined together in a common endeavor, interest, attitude, or set of values” (p. 6). This definition implies that the therapeutic alliance is a two-sided relationship that is experienced by both the client and the therapist.

Some of the research on alliance in individual therapy has indicated that the client’s rating of alliance is more predictive of outcome than the therapist’s (Horvath & Bedi, 2002; Horvath & Symonds, 1991; Martin et al., 2000). Some research has conversely found that the therapist’s rating of the alliance can be as strong a predictor of outcome as the client’s (Frank & Gunderson, 1990; Gaston, Marmar, Gallagher, & Thompson, 1991; Marziali, 1984).

Research has shown that there is a difference in how alliance affects outcome in individual therapy versus couple’s or family therapy. One meta-analysis of individual
therapy literature (Horvath & Symonds, 1991) found that both clients’ and observers’
perception of the alliance was more strongly correlated with outcome than the therapist’s perception. However, these same researchers conducted an empirical study in 2004 that focused on aspects of the therapeutic alliance in couple’s therapy which found the opposite to be true. Forty seven couples were given a battery of outcome measures at the beginning and end of treatment. The clients and their therapists also completed a couples’ version of the Working Alliance Inventory (Symonds, 1999) at several stages of treatment. Their results indicated that the client’s rating of the alliance was not significantly correlated to outcome, whereas the therapist’s rating showed a significant positive relationship. The researchers discussed the complicated interplay between the client couple’s allegiance to each other and their alliance to the therapist, and suggested that “the strength of the [therapist-rated] alliance may be a more direct measure of the relationship and be less influenced by collateral relationships” (p. 452).

Further research has not sufficiently addressed the issues presented in this study, as literature on alliance in family and couple’s therapy is sparse. It is clear, however, that the therapist’s perception of the alliance was shown to have a significant correlation with outcome in couple’s therapy. Although the current study did not utilize alliance assessment measures with the interviewed therapists, they were asked to comment on their experience with developing alliances over years of therapy.

Bilingual therapy undeniably affects the therapeutic alliance. Language is used to communicate affect and connectedness between one person and another. Empathy requires the ability to make another person feel heard and understood at a deep and specific level of intimacy. Non-verbal cues convey some of this understanding; however,
appropriate verbal cues including tone, shades of meaning, fine distinctions, and
gradation of words are inherent in conveying understanding, acceptance, and
confrontation. Without the therapist’s ability to do this, the alliance suffers.

Literature in the area of therapy for deaf clients has shown that there are
techniques that therapists use to overcome the language barrier. One such technique is to
utilize the strengths of the language (in this case American Sign Language) to therapeutic
ends. This includes an increased usage of storytelling (Phillips, 1996), and differentiating
and labeling affective experiences (Corker, 1996; Kaufman, 1996). Furthermore, hearing
therapists working with deaf clients are counseled to learn appropriate eye contact norms
(Williams & Abeles, 2004), master different rules of personal space (Phillips), and
become more attuned to non-verbal communication (Corker, 1994). Some researchers
have stated that nonverbal behaviors play a more important role in communication
between two people than verbal behaviors do (Archer & Akert, 1977; Haase & Tepper,
1972). Hill (2004) noted that non-verbal behaviors convey what people are trying to
express as well as what they might be trying to hide. Although the literature does not
address the same issues with regard to Spanish language therapy, it is speculated by this
researcher that similar techniques are employed by these therapists as well to compensate
for the difficulties encountered as a result of the language barrier.

The Role of Language

Language is an important means of expressing an individual’s heritage and is a
source of identity and pride (Altarriba & Santiago-Rivera, 1994). If the therapist is unable
to speak the dominant language of the client proficiently, it may have potentially
damaging effects on the outcome of therapy (Altarriba & Santiago-Rivera; Bamford,
1991; Padilla et al., 1989), though it is unclear what aspect of therapy is affected the most by language differences. Studies have shown that Spanish-speaking clients are more positive about their experience in treatment when their therapists are bilingual or when interpreters are used (Marcos, Alpert, Urcuyo, & Kesselman 1973; Padilla & Salgado de Snyder, 1988).

Vivero and Jenkins (1999) highlight the pitfalls of using an interpreter by noting that the “literal translation of words from one language, culture, or context to another does not translate the emotional meaning; often something gets lost in the translation” (p. 18). The use of an interpreter in therapy can cause feelings of exclusion from the relationship of the client and the interpreter, occasional feelings of anger or frustration toward the interpreter, and complex triadic emotional interactions (Miller, Martel, Pazdirek, Caruth, & Lopez, 2005). At any time it is possible, therapy with a well-trained bilingual therapist is more helpful than working with an interpreter.

Biever et al. (2002) addressed the need for more effective training in multicultural counseling for masters and doctoral level students. Their review of counseling, clinical, and school psychology training programs suggested “students have not been provided with the requisite knowledge and skills to competently serve culturally and linguistically diverse clients” (p. 332). One of their major assertions was that students who are proficient in two languages were able to simply translate their training in English into the second language and be just as effective in both contexts. This assumption was not supported. The researchers found that students in their program expressed frustration at their ability to utilize English-language training in Spanish. This frustration was found across all aspects of the therapeutic process, including assessment, diagnosis, and
treatment. The data in the Biever et. al. study was collected by means of an informal survey of graduate students at one university. A study with a more traditional design would lend further credibility to their plausible, but non-empirical findings. The current study specifically addressed the issues confronted by native English-speaking therapists, whereas Biever et al. studied the role of language in training with many different types of bilingual therapists, both native Spanish and English-speaking.

In spite of all of these difficulties concerning language in the therapeutic process, some areas of clinical intervention likely benefit from the language barrier. Research has also shown that struggles between the therapist and client increase if the therapist uses technical diagnostic labels directly with the client (Miller, Benefield, & Tonigan, 1993). Therapists who must translate into a second language are less likely to use diagnostic labels with their clients. Furthermore, Sache (1993) found that therapeutic interventions that were communicated to clients clearly and without excessive technical language were more likely to be followed and implemented by the client. Again, therapists who must communicate in a second language often use less technical language and attempt to communicate in a conversational style. This is beneficial to the therapeutic alliance because it bridges the potential gap between clinician and client.

**Emotion and Language**
Exploring emotion is an important part of the therapeutic process. Coombs, Coleman, and Jones (2002) studied the effect emotion played on outcome in a sample of 64 clients from the NIMH–TDCRP study, all of whom were receiving treatment for depression. They found that collaborative emotional exploration was significantly positively related to outcome in both Cognitive
Behavioral Therapy and Interpersonal Therapy. Jones and Pulos (1993) noted that interventions that compelled clients to explore and express their emotions were significantly positively correlated to four of the five outcome measures used in their study. One of the goals of this study was to explore the therapists’ experiences in exploring emotions with their client while working in Spanish as a second language.

Language independence theory holds that bilinguals maintain two separate language systems which results in differing types and levels of emotional expression in each language. Inherent in this theory is the belief that the native language – the language learned in the first years of life – is the language in which emotion is experienced and expressed most intensely (Kaplanski, 1997). In their study on the measurement of the therapeutic alliance in family therapy, Friedlander, Escudero, and Heatherington (2006) included emotional connection with the therapist as one of four dimensions on which they assessed the therapeutic alliance. Sexton, Hembre, and Kvarme (1996) studied the interaction of the therapeutic alliance and several microprocesses of therapy. They found that clients who rated their therapeutic alliance as high were more involved in an alternating pattern of therapist-client emotional engagement than were low-alliance clients (Sexton et al.). In other words, clients who felt more connected to their therapists reported an emotional give and take during the therapeutic process. Furthermore, Gladstein (1983) stated that empathy includes an important affective component that enables a therapist to respond “with the same emotion to another person’s emotion” (p. 468). It follows, then, that therapists’ inability to
express or experience emotion in the language used in therapy would hinder their ability to form a strong therapeutic alliance, as well as their ability to deliver effective services to their Spanish-speaking clients.

Gonzalez-Reigosa (1976) stated that a person’s native language is the one in which early childhood memories are coded and labeled. “Expressions in this mother language are the first ones to be rewarded or punished, and it is in this first language that feedback is offered” (p. 93). Gonzalez-Reigosa’s study further supported the theory of language independence. Participants were all native Spanish-speaking bilingual males. All participants were grouped together according to English proficiency. Each participant was given a series of words in English and Spanish, each word being either taboo or neutral. Interestingly, Spanish taboo words evoked significantly more anxiety than both English taboo and neutral Spanish words. This study further demonstrated the importance language played in the affective experience of bilingual individuals. Finally, by turning the finding of Gonzalez-Reigosa’s study to its converse expression, it is important to note that people using a second language may be less able to express and experience emotions in a meaningful fashion.

Therapist Self Experience

Sprowls (2002) studied the experience of bilingual therapists working with bilingual clients. She conducted a series of qualitative interviews in the form of focus groups with 2-3 participants per group, with the focus of the interview being the self-experience of the therapists as they conducted bilingual therapy. The nine subjects were students and professionals who provided services in English and
Spanish to bilingual clients. Eight of the therapists interviewed were Latino, and one was Caucasian. Although four of the participants were native Spanish speakers, all agreed that language barriers were significant in attempting to provide services to the Latino population. Results indicated that the language barrier included translation difficulties, use of humor, and use of technical language that was learned in English.

Sprowls (2002) identified eight themes: Translation, Culture and Connection, Confidence, Boundaries, Language Switching, Identity, Expectations, Therapeutic Relationship. Translation addressed the difficulty encountered in translating things from one language to another, lack of proficiency in professional vocabulary in Spanish, and the use of humor, metaphors, and slang. Confidence addressed the importance of training and the concept of always learning and improving. Identity referred to the therapists’ sense of self in different languages and their use of self in each language. This theme was explored in the current study by investigating how the therapists experienced themselves when speaking Spanish as opposed to English, and how they perceived the difference affected the therapeutic relationship. Expectation involved both the clients’ expectation of the therapist and the therapists’ expectation of the client. Finally, Therapeutic Relationship addressed difficulties found in small talk, gender differences, and having a more personal style during therapy.

This study focused exclusively on second language Spanish speakers whereas most of the interviewees in Sprowls’ (2002) study were native Spanish speakers. This difference is important because of the challenges inherent in
practicing therapy in a second language, as opposed to working in a native language or conducting bilingual therapy, which were the foci of Sprowls’ study. Furthermore, the current study focused exclusively on the effects of language on the therapeutic process and relationship

**Summary of the Review of Literature**

In summary, the review of literature indicated that there are four components of working in a second language that impact therapy:

1. Latinos are an underserved population in the context of mental health, and there is a need for further development of culturally sensitive and appropriate techniques and modalities.

2. The therapeutic alliance is one of the integral parts of the therapeutic process, regardless of culture.

3. Language plays an important role in the development of the therapeutic alliance.

4. Emotion is more strongly expressed and felt in a person’s first language, which has implications for both therapist and client emotional expression in therapy.

**Significance of this Study**

In light of the staggering influx of Latino immigrants into the country in the past ten years, it is imperative that the mental health community improves its understanding, techniques, and training in the field of multicultural therapy. This study identified and discussed the effectiveness of techniques and strategies utilized by second-language-Spanish-speaking therapists who work with native-Spanish-speaking clients.

This study is important because it addresses and explores the experience of the bilingual clinician, whereas the overwhelming majority of the literature in the
multicultural therapy movement is focused on the client. Gaining a better understanding of the experience of the clinician will enable us to understand further the therapeutic process when a language barrier accompanies the cultural barriers that are inherent in multicultural therapy.

Research Questions

Based on the review of literature, the following research questions were proposed:

What is the therapeutic experience of therapists working in Spanish as a second language? More specifically, what are the major challenges confronted by therapists working in Spanish as a second language? What are the coping strategies employed by therapists to compensate for the language barrier? How do the therapists describe the differences in their therapeutic alliance with Spanish-speaking and English-speaking clients?
CHAPTER II: METHODS

Design

Qualitative Research

A qualitative design was selected for this study because it allows less objective data to be collected, coded, and analyzed. In this case, a qualitative design allowed the researcher to investigate the individual experiences of bilingual but non-native-speaking therapists involved in working with clients in a second language. The subtleties of this experience are best identified through dialogue, in which clarification and expansion of concepts is possible.

Qualitative research allows the researcher to return to the experience of the phenomenon to obtain comprehensive descriptions that portray the essence of the lived experience (Moustakas, 1994). The researcher pursues research questions that may change as data is collected (Franklin & Jordan, 1997). Participants are selected based on their involvement with the area of research and the data is collected at their offices where they see clients. The researcher is the primary instrument of data collection, admits to biases, life experiences, and other beliefs associated with the study, and strives to record the subjective reality of the participants (Gilgun, 1992). Patton (1990) writes, “For evaluators, the inductive search for patterns is guided by the evaluation questions identified at the beginning of the study and focuses on how the findings are intended to be used by intended users” (p. 405). Data from in-depth interviews are analyzed and coded by a research team using interpretive methods rather than mathematics or statistical measures.
Grounded Theory

Grounded theory is a method of qualitative research that was devised by Glaser and Strauss (1967; Strauss, 1987). It involves collecting data from the field of experience and coding it into analyzable groups and sub-groups. The term “grounded theory” refers to the idea that theory is “derived from data, systematically gathered and analyzed through the research process” (Strauss & Corbin, 1990). The researcher generally does not begin with a theory in mind; rather, the theory emerges from the data as the research progresses.

Participants

The researcher solicited a convenience sample of participants from various mental health clinics and private practices located in urban areas of Northern Utah including Salt Lake City, Ogden, and Provo. Twenty-three therapists were identified who offered services to Latino clients. These therapists were contacted and invited to participate in this study. Criteria for inclusion in the study stipulated that the therapists spoke Spanish as a second language, that 25% of their caseload consisted of Spanish-speaking clients, and that they were licensed practitioners or graduate students in an accredited mental health program.

Five of the potential participants were eliminated because less than 25% of their clinical work was conducted in Spanish. Eight of the participants contacted were unavailable for participation in the study for various reasons including disinterest and time constraints.

Ten participants were willing to participate in an in-depth interview with the researcher, as well as any follow-up questions raised during the analysis. Qualitative
interviews were conducted with these ten native English-speaking therapists who did more than 25% of their therapeutic work speaking Spanish with native Spanish-speaking clients until saturation was achieved. The lead researcher conducted all of the interviews, and the lead researcher and his faculty advisor determined saturation jointly. When the interviews collected ceased to yield any new and relevant information, the lead researcher determined that theoretical saturation had been reached. The participants did not all agree with each other, but their responses to the interview questions began to appear repetitive and it was determined that the data was sufficient for analysis.

Procedures

An interview was conducted at the clinical site of each participant who agreed to be a part of the study. The interviews lasted between 25 minutes and one hour. Each participant was provided with an informed consent form authorizing the researcher to extend confidentiality to the research team. Participants were asked not to use any first names during the interview and the researcher followed the same protocol to ensure the highest level of confidentiality. The face-to-face interviews allowed the researcher to track non-verbal behavior and guide the interview accordingly. Although the interviewees were encouraged to elaborate and provide their own information, probing questions were used to stimulate and guide the discussion. The interview protocol is provided in Appendix A.

It is important to note that during the interviews new ideas and questions were generated by the answers of the participants. In order to avoid lending increased influence to later interviews, the researcher included a participant check, in which he contacted the participants that he had interviewed before the new concept was introduced, and invited
them to add any more information related to the area probed. The follow-up questions were asked by telephone to minimize further intrusion in the work schedules of the participants. The phone conversations were recorded, transcribed, and stored according to the same protocol (described below) that was utilized for the original interviews. These new ideas were integrated into the original interviews, and were included in the transcription process.

The interviews were recorded on a digital tape recorder with a lapel microphone that was placed on the subject for the interview, and the recordings were transcribed by members of the research team and one assistant. The recordings and transcriptions were stored on a secure server in a university computer lab throughout the research process. The research team trained itself in transcription by using a preliminary interview, and each member was informed as to the confidentiality of the interview recordings to which they were given access. The resulting transcriptions were checked by members of the research team against the original recordings to ensure verbatim accuracy. Further verification of the transcripts’ accuracy was achieved by providing a copy of the transcript to each participant and asking them to verify the accuracy of the transcription. Each participant responded that the transcription was accurate to their recollection.

The interviews continued and data was collected until theoretical saturation was achieved (Strauss & Corbin, 1990). Saturation was determined by the interviewer and his faculty advisor as they saw that no new themes or concepts were emerging from the interviews the researcher conducted.
Analysis of Data

The interviews were recorded, and the recordings were transcribed for coding and analysis. The research team consisted of four students in the Marriage and Family Therapy Graduate program at Brigham Young University. Two of the team members had been previously trained in the grounded theory research methodology, and the lead researcher trained the other two. The training began with an in-depth reading of Basics of Qualitative Research (Strauss & Corbin, 1990) over the course of about three months, with weekly meetings to discuss salient issues that emerged from the readings. The researcher conducted a pilot interview to be used in training the research team. The entire research team reviewed the interview and reached a consensus on the themes that emerged from the analysis.

The team consisted of two male and two female student therapists; three of them were working towards their masters degrees, and one was working toward a doctoral degree. Each member of the team received a copy of the transcripts from each interview, numbered sequentially from 1 through 10. The team was then instructed to begin reading the transcripts and deciphering themes, categories, and sub-categories. It is important to note that grounded theory can have the effect of giving weighted influence to the initial interviews and increasingly diminished influence to subsequent interviews. For this reason one team member was instructed to read from interviews 1-10 sequentially, another member from 3-10 and then from 1-2, another member from 5-10 and then from 1-4, and the last member from 7-10 and then from 1-6. This eliminated the potential bias towards the information in the first interview by distributing researchers’ attention evenly among all the interviews.
CHAPTER III: RESULTS

Description of Therapists

As shown in Table 1, the participants in the sample ranged from 26 to 66 years of age, with the average age being 34.9 years. Nine of the ten participants were male, and all ten participants were Caucasian. The single female therapist’s responses were not unlike those of the other therapists interviewed so she was included in the analysis. All of the therapists interviewed reported being actively religious in the Church of Jesus Christ of Latter Day Saints. Eight of the ten participants learned Spanish while serving as missionaries for their church, one learned Spanish in school and another reported being self-taught. Five of the participants reported having inlaws or close friends that were Latino, while the other five reported having no contact with Latino culture or language outside of therapy. The average number of years of experience of the sample was 8.7 years, with the most experienced having 40 years of experience, and the least having 1 year. The average number of years of experience in Spanish language therapy was slightly over 8 years, with a range of 1 to 40 years. The average percentage of overall clinical work conducted in Spanish of the sample was 39%, with the highest being 75%, and the lowest being 25%. This sample included two student therapists in training and eight therapists licensed to practice mental health therapy in the state of Utah. Both of the students in the sample were studying Marriage and Family Therapy; one was in a Master’s Program and the other was in a Doctoral Program. The licensed participants included four Marriage and Family Therapists, five Social Workers, and one Counseling Psychologist. One of the participants worked in a private practice setting, while the 9 remaining subjects worked in community clinics. Two of the subjects reported working
frequently in group therapy, while the rest of the subjects reported seeing a combination of individual and couples clients (See Table 1).
Table 1: Demographic and Descriptive Data of Therapist Sample

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Key:
BA=Bachelor of Arts
MFT=Marriage and Family Therapy
MSW=Master of Social Work
Identification of Themes

Approximately 120 pages of interviews were transcribed and coded by the research team. Individual members of the research team looked intensively at each interview to determine what was relevant from the data. As mentioned above, each member of the team studied the interviews in a different sequence to ensure that no one interview received more weight than another. The research team held two meetings to synthesize their findings for each interview. The group coding for each interview was then organized into a “skeleton” that represented the various categories, sub-categories, and groups that were derived from the transcript. The skeleton contained only those codes that were related to the question of language.

The lead researcher undertook the synthesis of these skeletons into one composite skeleton that represented all of the interviews. The therapists interviewed discussed many aspects of their experience in Spanish language therapy, and they were all grouped into categories. The themes that emerged from the analysis included several categories such as Personal, Language, Alliance, and Cultural. The Personal category included obstacles and benefits to the therapist himself, as well as measures taken to compensate for the difficulty of doing therapy in a second language. Language specifically addressed obstacles and benefits related to speaking the foreign language in therapy, and compensations made in and out of therapy to make up for the language difficulties. Alliance identified obstacles and benefits on the therapeutic alliance, and compensations made to better the alliance in light of the language barrier. Each of these categories contained three sub-categories: Obstacles, Benefits, and Compensations. Another category, Cultural, was created to encapsulate those ideas that exclusively addressed
cultural differences mentioned by the participants. Some ideas and concepts discovered at this phase did not fit into these four categories, nor were they cohesive enough to fit in a category of their own. These were coded under the category “Unassigned.” The final analysis contained 177 codes assigned to the above-mentioned categories, and 17 unassigned codes. The resulting document was divided into four parts and each member of the research team was charged with identifying relationships between the various concepts included under each theme.

The results of the coding process included the following three themes: *Perceived Obstacles to Second-Language Therapy*, *Compensatory Coping Strategies*, and *Facilitative Beliefs About Spanish-Language Work Experiences*. These three themes will be described briefly here, and will be examined more closely in the following chapter.

*Perceived Obstacles to Second Language Therapy*

Each of the participants in the study discussed things that made therapy in a second language more difficult for them than in their native English. These issues ranged from personal difficulty encountered in speaking a language in which one is not entirely proficient to differences noticed in the formation of the alliance.

*Compensatory Coping Strategies*

Many of the therapists interviewed discussed certain strategies they employed to prepare themselves to offer competent services to the Spanish-speaking community. Some of these were intentional, conscious decisions they made, and others were more implicit in the answers they gave to the researcher. These coping skills compensate for the obstacles that were unavoidable in their second-language work.

*Facilitative Beliefs About Spanish-Language Work Experiences*
Each of the therapists interviewed for this study expressed certain beliefs that enabled them to continue offering services in Spanish in the face of some intense difficulty. These beliefs gave the therapist a positive spin on their experience, and enhanced their belief that doing therapy in Spanish is worth the added effort it takes to do therapy in a second language.

Themes

Perceived Obstacles to Second-Language Therapy

Each of the therapists interviewed \((n = 10)\) discussed obstacles that they had encountered in practicing therapy in a second language. Their experiences were varied, and the most commonly reported difficulties are listed below in alphabetical order.

Differences in the Alliance-Building Process

More than half of the therapists \((n = 6)\) interviewed mentioned that the building of the therapeutic alliance was different in Spanish language therapy than it was in English. Some participants discussed explicitly the difficulty they had in building alliances with their Spanish-speaking clients outside of language difficulty. One therapist noted:

“the quality of the alliance may … suffer sometimes … depending on … the client’s previous experience with … English speaking men … and that can suffer and sometimes even maybe scuttle therapy … there are a certain … proportion of cases that…don’t come back because the alliance … doesn’t form…[one] reason would be just that general mistrust based on their previous experiences.” (Subject 1)
This therapist’s observation revolved around the cultural differences between a non-native Spanish-speaking therapist and their Latino clients.

*Difficulties with the Language Barrier*

The language barrier was identified as a pervasive obstacle discussed by the participants. They discussed language differences as a problem both in the formation of the alliance and throughout the therapeutic process. All of the therapists interviewed brought up the language difficulties they experienced when doing therapy in Spanish. The perceived obstacles to second-language therapy were described in a variety of ways as discussed below.

*Difficulty of Expression.* Nearly all of the therapists interviewed (*n* = 9) discussed having problems (from occasional to frequent) with expression of their thoughts and feelings in Spanish. Subject 1 discussed the extra mental energy he required to do therapy in Spanish, because “there are simply some things I cannot say very well in Spanish still.” It was not surprising that second-language Spanish speakers would almost universally report this observation, but it was an important factor in understanding their experience in second-language therapy.

*In-Session Translation.* Two therapists discussed the difficulty they had encountered when they had to translate for a Spanish-speaking client into English for a spouse or child who did not know (or refused to use) Spanish. The therapist was then caught in a language crossfire, having to constantly switch between Spanish and English to accommodate his/her clients. Subject 4 called it “the burden” of being both a translator and a therapist to a family. Having to switch
from one language to another repeatedly during a session was particularly taxing for these therapists.

*Language Fluency Decreases with Time.* The realization that language fluency decreases with time was a burden for bilingual therapists, depending on their individual attitudes. Four of the ten therapists interviewed mentioned this phenomenon during their interview. Subject 9 was asked to describe his level of fluency in Spanish, and he responded, “It has decreased over the 20 years.” Even though he had been practicing Spanish-language therapy for two decades, his language fluency had weakened as the years passed.

*Modality Restraints.* Some of the therapists (*n* = 3) interviewed reported that they felt hindered in their therapeutic approaches because of the language barrier. Subject 4 discussed this concept when he noted, “it is more difficult to follow a specific model, a therapeutic model, just because of the translating involved.” As in this example, this obstacle was often discussed in relation to the difficult translation of technical terms and concepts; however, it was also brought up in the context of cultural differences and the struggle to find and utilize culturally competent models to work with their clients.

*More Mental Energy.* Half of the therapists (*n* = 5) interviewed felt that doing therapy in Spanish was more mentally draining than doing therapy in English. These therapists reported leaving their Spanish-language sessions more tired than their English sessions. This observation negatively contributed to the overall experience of the therapist in Spanish-language therapy.
Translation of Technical Terms. Most of the therapists interviewed \((n = 6)\) mentioned the difficulty they found in translating technical terms. For example, Therapist 8 reported that “There is no word for Stonewalling in Spanish, at all. So you have to walk around that word, and find some other way of describing that.” This difficulty was seen to have a dual effect on the therapeutic process: in some cases it frustrated the therapist, in others it kept the therapist’s language simpler and less technical.

Compensatory Coping Strategies

When discussing how they dealt with the difficulties of working in a second language, the participants mentioned a wide variety of coping strategies. Although their strategies were not all the same, all ten of the therapists interviewed discussed at some length the ways they strove to improve their bilingual practices. These strategies were grouped into three sub-categories: Therapy Skills, Language Skills, and Immersion.

Compensatory Therapy Skills

Compensatory Therapy Skills refers to the coping skills that therapists reported utilizing during sessions with the clients. Because all of the therapists interviewed perceived some level of a language barrier, it became important for them to adjust their clinical strategies to compensate for the difficulties they encountered. Their responses are described below in alphabetical order.

*Announce language comprehension.* Some therapists \((n = 5)\) reported that they made an effort to let their Latino clients know that they were proficient in the
language as a means of reassuring the client that they would be able to express themselves completely in their own language. One therapist reported:

“I’m able to kind of open doors and let them know that I am competent, that I’m able to speak the language to a level to where … they can freely express themselves and that I’m going to be understanding what they’re talking about, in a wide variety of topics.” (Subject 8)

When analyzed to include several other variables, this specific therapy skill appeared to be a particularly effective technique. All five therapists who utilized this technique also reported that they perceived that the clients were very grateful to have a therapist that spoke their language. In addition, two therapists reported that announcing their language comprehension helped to build an alliance with Spanish-language clients and actually made it easier to build than with their English counterparts.

*Attend to non-verbal behavior.* Most of the subjects interviewed *(n = 6)* stated that they paid closer attention to non-verbal communications as a means of compensating for the difficulty in communicating in a second language. Subject 3 discussed situations in which he had difficulty understanding the words a client was using: “I might be able to see that something’s going on non-verbally, but I don’t necessarily understand the exact details of what it is they are trying to say.” In this context paying attention to non-verbal behavior became a heightened second sense that bilingual therapists developed to compensate for their own deficiencies in the verbal language realm.
Focus on client’s culture. A majority of the therapists interviewed ($n = 7$) discussed their efforts to focus on the client’s culture as a means of building the alliance. For example, one therapist’s closing message was about one way to strengthen the alliance:

“…the more someone’s willing to explore and be engrossed in the culture, not just … know the language, which is an area I can improve on as well, it’s always going to help a person to be more approachable.” (Subject 9)

Humor. Using humor with their Spanish-speaking clients helped some therapists ($n = 5$) build the alliance. Many saw this as a cultural adjustment they made to accommodate what they perceived as a difference in Latino culture: “I tell a lot of jokes … sometimes I’ll tell more with Hispanics, because … it seems they like to laugh.” (Subject 2). Other therapists reported that they used humor to break the ice, a reaction to their perception that the alliance is more difficult to establish with Spanish-speaking clients.

Language Skills

Language Skills refers to those strategies participants reported using to help build their own personal language skills for use in therapy. Each of the therapists interviewed ($n = 10$) discussed strategies in this sub-category. Increasing one’s language skill helped to make the client feel more at ease with the process, minimized the effects of the language barrier, and lessened the potential anxiety experienced by the therapist by minimizing language mistakes in session. Responses in this sub-category are listed below.
**Build language skills.** The majority of therapists \((n = 7)\) interviewed reported spending time outside of work enhancing their language skill in a variety of ways. Some of the methods mentioned included watching the news in Spanish, listening to Latino music, studying Spanish grammar and vocabulary, reading other Spanish-language literature, and speaking Spanish with other colleagues.

*Stay in the “language groove.”* Several of the therapists \((n = 5)\) interviewed discussed how their Spanish got better the more Spanish-language work they did. Although this may appear to be an obvious truth, the therapists listed two ways to respond to it. Two therapists said they attempted to maximize their Spanish-speaking caseload to keep their language in good practice. Another strategy discussed was scheduling Spanish-speaking clients consecutively, because “if I get into a Spanish-speaking groove, I get better as the day goes on.” (Subject 6)

**Immersion**

Each therapist commented on their level of immersion in Latino language and culture. Each participant was asked to quantify the degree of immersion they experienced by saying they felt they were “not very,” “somewhat,” or “very” immersed. Although all the participants were Caucasian, five of the ten participants reported that their immersion level was influenced by having Latino in-laws and acquaintances outside of a therapy setting. This gave them a built-in relationship outside of therapy in which they were able to keep their language skills sharp, and stay in touch with Latino culture.
Facilitative Beliefs About Spanish-Language Work Experiences

Although the bilingual therapists identified coping mechanisms they used to deal with obstacles encountered in Spanish-language therapy, they also expressed a variety of beliefs and ideas that enabled them to continue to offer services in spite of the difficulties. These constructions helped the therapists to justify their continued effort to serve the Latino population. This category is divided into two sub-categories: Perceived Benefits to the Therapist, and Altruism.

Perceived Benefits to the Therapist

Only one therapist did not identify personal benefits as a motivation to provide Spanish-language therapy. The other therapists noted certain benefits that they perceived compensated them for the difficulties they encountered. These benefits were important to them and served to compensate for the difficulty, obstacles, and stress of offering services in Spanish to the Latino community.

Second-language therapy is enjoyable. The majority of therapists (n = 6) interviewed made explicit mention of how much they enjoyed therapy in Spanish, and the remaining alluded to it more indirectly at least once in their interview. The personal satisfaction of doing therapy in Spanish was one of the most universally cited motivations by the participants. For example: “I really like doing therapy in Spanish … because every time I feel like I am getting better.” (Subject 6)

Therapy helps to maintain language fluency. Again, the majority of therapists (n=6) reported that practicing in Spanish helped them to maintain their fluency in the language. For these therapists, there was inherent value in being able to speak Spanish outside of a professional setting. Offering Spanish-language
services helped them to maintain their language fluency, thus preserving this valuable skill. One therapist reported feeling, “fortunate to maintain the fluency of Spanish.” (Subject 9)

**Latino clients are more compliant.** Several therapists \((n = 4)\) mentioned that they believed Latino clients to be less resistant to the therapists’ interventions and more compliant with assignments. Therapists in this study felt that this was a benefit to them. They expressed that it was one way in which Spanish-language therapy was slightly easier for them than English-language therapy. Speaking of their Latino clients, one therapist reported,

> “they’re very willing to try what you tell them … I try to get them to come up with the ideas, but sometimes I just give them some options, and they’re … more likely to do that than sometimes English clients are … typically it seems like they look to…professionals for advice, instead of finding everything out for themselves.” (Subject 10)

**Altruism.**

All the therapists \((n = 10)\) discussed aspects of their work with Spanish-speaking clients that satisfied their desire to “give back” to the Latino community. This sense of altruism was common among all therapists, though it was heightened by the concept that they were offering services to an under-served minority population. The following beliefs were categorized as altruism: Sense of Service, More Compassion/Empathy, and Latino Clients are Grateful.

**Sense of charity.** A related personal belief was termed a “sense of charity.” Most of the therapists \((n = 7)\) reported feeling like their work in Spanish was a
kind of service they gave to the Latino community. This concept of the benevolent service aspect of the work was seen as a powerful motivator for a clinician to continue in this work. It gave incentive to continue practicing in Spanish, even when confronted with all the difficulties inherent in the work.

The sense of charity contributed to the high-power position in which a Spanish-speaking clinician found him/herself. When a clinician had a certain skill in speaking Spanish, he/she could choose to use or not, it became an act of service, and almost a favor when he/she decided to offer it to the community. The therapists spoke about the sense of service they felt as they treated Spanish-speaking clients. Some of them spoke about the pride they felt as pioneers of Spanish-language services in their communities, and nearly all of the participants appeared to perceive themselves as the benevolent provider: They felt pride in being able to practice in Spanish, and they pitied those clients who had languished for so long without access to such competent services. One therapist described a compliment he was given by a new Spanish-speaking client he was beginning to work with: “He (the client) said I spoke Spanish better than anyone he had spoken with since he was here … which was very nice, but also very sad.” (Subject 2) This therapist received a bit of ego massaging each time his language was complimented, but then he expressed his sadness over the plight of his client. This pity for the immigrant client put the therapist in somewhat of a rescuer position, which, in turn, motivated him to continue working in Spanish; he felt that the Spanish-speaking client needed him more than his English-speaking clients did.
More compassion/empathy for Latino clients: Some of the participants interviewed (n = 3) noted that they felt more compassion or empathy for their Spanish-speaking clients. One therapist was discussing the difference between his Spanish- and English-speaking clients:

“A lot of times I feel like my Latino clients have harder lives that my English-speaking clients, I don’t feel that a lot of my Latino clients are born into privilege. Some are here illegally, some are here legally, but in low social-economic status … so I feel like they struggle more, and so I feel like … just letting them know that I understand that they struggle.”

(Subject 6)

Latino clients are grateful. Seven of the ten therapists interviewed spoke about how grateful their clients were just to have someone that was trying to speak their language. This was usually mentioned in the context of language errors, in a way that indicated that the clients understanding made it easier on the therapist who might otherwise have become preoccupied with language specifics. For a few therapists, they believed that to speak Spanish compensated for some limitations in their therapeutic skills.

God’s work. One interview of the ten stood out as exceptional in many ways. This outlier was initially puzzling to the research team. It was determined that this therapist’s belief that he was doing “God’s Work” was at the root of the discrepancies that separated his from the other interviews analyzed. This therapist made repeated mention that Spanish was “God’s language” and alluded to using such a proclamation several times during the therapeutic process. This therapist
also reported that most of his Spanish-speaking clients were referred by Domestic Violence Courts, and most of them were less interested in spirituality than his English-speaking clients. In spite of this disinterest in things of a spiritual nature, this therapist reported efforts to include spirituality in session with Spanish-speaking clients. This gave an evangelical air to the interview that began to explain why this particular data stood out from the other data.

This therapist further cemented his belief of being on God’s errand when he discussed the positive effects he perceived Spanish-language work had on his personal development:

“I find that most of them enjoy working with me, and especially those that haven’t been able to find Spanish-speaking therapists and who need a therapist … they’re usually quite relieved and … they’re quite happy, so I feel like it’s positive.” (Subject 2)

Several other therapists expressed their satisfaction with the gratefulness of their clients, but this interview was unique in its portrayal of the therapist as the “last hope” of the Latino clients. This personal belief was so powerful and sustaining that the therapist was able to essentially bypass many of the obstacles noted by the other participants. He mentioned only one therapeutic obstacle during his interview while each of the other therapists mentioned about four each. He identified only three coping skills he utilized to compensate for the language difficulty in contrast to the other participants who each identified six or more.

It is interesting to note that although most therapists experienced their altruism and sense of spirituality being increased while doing therapy in a second
language, only one felt that “doing God’s work by speaking in the client’s language” was as important as high level clinical skills.
CHAPTER IV: DISCUSSION

This study has enhanced our understanding of the experience of second-language therapy for bilingual therapists. The results of the analysis of data demonstrate some of the various obstacles, coping strategies, and facilitative beliefs that bilingual therapists experience when doing therapy in Spanish.

The participants agreed on several difficult obstacles that they perceived complicated their experience in offering Spanish-language services to their communities. They reported that these obstacles threatened their ability to establish the therapeutic alliance, and that they affected their own personal comfort level while doing therapy. There was added pressure for clinicians to maintain their level of fluency, spend extra time building the alliance, and ensure cultural sensitivity in light of the modality restraints that were placed on them by their imperfect communication skills.

Many coping strategies were employed by these therapists in response to the obstacles they faced. These included techniques that were employed both inside and outside the therapy room. Therapists tailored their therapy styles to meet the needs of clients, as well as to adjust for their own language limitations. They made changes in how they scheduled their clients, as well as the amount of Spanish-language clientele in their practices. These changes facilitated the therapeutic process both for the therapist and the client. In light of the obstacles that were perceived by the therapists, these were some of the most important results in the study.

Finally, the therapists discussed the differences they perceived in the therapeutic alliance with their Spanish-speaking clients. They often perceived a more pronounced air of hierarchy in the therapist/client relationship. It was widely stated that Latino clients are
more compliant, and that they are grateful for the bilingual therapists’ services. Several therapists communicated a sense of charity for their minority clients. When these feelings border on “pity” or approach reverence for the client or their situation, it is possible that they could adversely affect the therapeutic relationship.

The following discussion will present implications for therapists who offer bilingual services to Latino clients. Limitations of the current study and implications for future research will also be discussed.

**Implications for Clinicians**

An important purpose of this study was to identify how bilingual clinicians can maximize both their own experience, and clinical effectiveness, in Spanish-language therapy. From the results of the interviews it is possible to identify three major implications that the participants perceived aided them to better equip themselves for the challenges and benefits of practicing in a second language.

*The Therapeutic Alliance*

The first implication for bilingual therapists is to focus on building up the therapeutic alliance with their Spanish-speaking clients. Participants who perceived that their Spanish-language alliances were better than their English alliances tended to report more success and personal comfort in doing Spanish-language therapy. Because there were no alliance assessment measures utilized in this study, it is possible that therapists who reported good alliances and overall success in therapy saw themselves and their work as more effective than they actually were. It is clear that these individuals felt comfortable and enjoyed doing therapy in Spanish with Latino clients. It is impossible from the data to determine if they actually were superior therapists to those who reported
having more difficulty. As reported in the review of literature, research, however, does support the concept that therapist-rated alliances can be predictive of outcomes as well (Horvath & Symonds, 2004). It appears from the interviews that strategies that help to build the alliance with a Latino client are of particular use to the clinician both for his/her own benefit as well as for that of the client. The building of the alliance emerged as one of the key components of perceived success in second-language therapy.

The research team believed that one of the most powerful techniques cited as a means of building the therapeutic alliance was “announcing” one’s language comprehension. This practice instills in the client a level of confidence that his/her story will be understood and properly addressed. There are many ways a therapist can accomplish this. Some of the participants discussed simply telling their clients that they spoke Spanish fluently and reassured them that they would be understood. This technique by itself may be of limited help. The research team encountered one respondent who appeared to be boasting about their language ability more than reassuring their clients, but the majority of those who used this technique were seen as doing so for the client’s benefit and not for their own aggrandizement. Additionally, it was used in conjunction with other ways of demonstrating the therapist’s ability to understand the clients’ experiences and expressions. Other means were reported that helped to reassure the client that they are being understood. Subject 9 reported that in spite of not speaking perfect Spanish, “they know that I’m there with them, that I can speak back to them … restate, reframe with them … they know … I’m on the same page with them. I’m keeping up.” The ability to restate, reframe, and reflect clients’ thoughts and feelings demonstrates to
the client that the therapist understands better than announcement of language comprehension.

Some therapists discussed taking a one-down position with their clients by apologizing for their language mistakes in advance, or even announcing their imperfect knowledge of the language. Those respondents who utilized this technique also reported less comfort in Spanish-language therapy. Subject 8 reported that he regularly had clients abruptly stop coming to therapy, which was inexplicable to him. This could have been a result of his working with a primarily domestic violence population or perhaps that many of his clientele were court-ordered. The research team speculated that his lack of confidence in the language was transferred to the client and undermined their confidence in his ability to offer them competent therapy, resulting in the higher attrition reported by the therapist. This well-meaning humility was seen as counterproductive because the clients may have been left doubting if they would be completely understood and his apology for his incompetence in the language may have also been interpreted as incompetence as a therapist. Most of the subjects in the study reported that their clients were understanding of their language mistakes. There is no need to call further attention to their errors by repeatedly apologizing for them. Therapists who reported assuring their clients of their competence concerning the language also reported having higher comfort levels and perceived having more success than the participants who did not use the same techniques.

In order to further build the alliance, the bilingual therapist focused on the culture of the client. This technique may work for a several reasons. First, the Latino client may be naturally uncomfortable in a therapeutic atmosphere, and the ability to talk about their
culture calms them and helps them to feel comfortable in this different, and sometimes anxiety-provoking, context. Second, the therapist that focuses on the client’s culture assures them that therapy will be tailored to their needs. The client is made subtly aware that the therapist is conscious that there are cultural differences inherent in their relationship, and they are comforted by the opportunity to discuss their experiences and beliefs.

Biever et. al. (2002) reported that translation of therapeutic techniques into Spanish was not sufficient for the therapists to feel comfortable in bilingual therapy. The respondents in the current study agreed with this finding, and elaborated on it by providing further ways of increasing their comfort and competence in second-language therapy. As with the hearing therapists working with deaf clients (Williams & Abeles, 2004) second-language therapists can minimize the language barrier by adapting their therapy to match the client’s needs. This includes tracking non-verbal behaviors more closely, and focusing on the client’s culture.

Five of the ten respondents in the current study reported using humor more often with their Spanish-speaking clients, which is consistent with the literature in this area (Sprowls, 2002). Therapists did this because they perceived that these clients responded more to humor than did their English-speaking clients. Humor, when used appropriately, can serve to create an atmosphere of openness and freedom, and can result in “an decrease in internal anxiety and an increase in the sense of belonging and social cohesion” (Richman, 1996). The participants perceived this to be of particular use to Latino clients, who often present to therapy more anxious and wary of the therapeutic process.
Another reported method of building the alliance was for the therapist to self-disclose their cultural experience with their Latino clients. Some therapists in the study sought out experiences through interactions with Latino relatives or peers. These relationships helped to make the clinician comfortable with the nuances of culture, language, and traditions of the Latino world. This added level of comfort for the therapist translated into the session, and helped the client feel more comfortable with the therapeutic process in general. Others attended various cultural activities and immersed themselves in activities, which were important to the Hispanic community. Furthermore, when the therapists made an effort to share these experiences with their clients, they showed their enthusiasm and affection for Latino culture, which also reassured the client that they were in the presence of someone who understood them. The result was a greater level of comprehension – both perceived and actual – between therapist and client.

Clinicians who implement this recommendation can do so by seeking out culturally-rich experiences, which are personally important and meaningful and sharing them with their clients in the context of self-disclosure rather than as calculated to impress the client.

One area of the therapeutic alliance that received attention in the literature review was the connection between the alliance and emotion. Language independence theory makes the assertion that emotions are experienced and expressed most intensely in a person’s native language (Kaplanski, 1997). It would follow that therapists practicing in a second language would have greater difficulty engaging with their Spanish-speaking clients on an emotional level, which would be detrimental to the therapist’s rating of the strength of the alliance (Sexton et al., 1996). This was not supported by the data in this study. None of the participants in the current study reported feeling less comfortable
expressing or working with emotion in Spanish-language therapy, in fact four of the participants reported that they experienced more emotion in Spanish than they did in English. Subject 9 was asked if working with emotions in Spanish posed any special challenges for him:

“They really has become more of an emotional expression … as they express things in Spanish … it seems to be a different tone, a different sensitivity … level. I [would feel] more expression … in Spanish.”

The perceived ability to experience more emotion in a second language could be attributed to this therapist’s reported “passion” for the language and the Latino people. Additionally, several other participants mentioned feeling an increase of empathy for their Spanish-speaking clients due to their status as immigrants, which could contribute to their reports of being able to experience emotion in Spanish.

The reports of the participants in this study do not support the assertions of language independence theory. Each of the subjects learned Spanish as a second language, and nearly half of them perceive that they experience more emotion in Spanish than they do in English. The rest of the subjects reported that they feel equally comfortable working with emotions in both languages. However, these findings were obtained using self-reporting measures, not empirically supported assessments of emotional experience. Nevertheless, this researcher asserts that the ability to experience or express emotion is not the relevant concern; it is the ability to understand and accurately reflect a client’s emotional content, both verbal and non-verbal. When engaging in an emotional give-and-take with the client, the therapist is strengthening the alliance (Sexton et al., 1996) as well as assuring the client that their verbal and non-
verbal communications are being understood. This added strength in the alliance would logically lend itself to improved therapeutic outcomes, though this finding was impossible to obtain here, given the methodological constraints of this study.

The Language Barrier

A second implication for clinicians was how to deal with the language barrier that plagues a second-language Spanish-speaker. This study suggested that a lack of confidence on the part of the therapist should be addressed in his/her own personal time, and should not become a part of therapy. Therapists who participated in this study perceived that Latino clients did not respond well to a clinician who excused him/herself for mistakes or persistently acknowledged a language barrier. Any such techniques should be used in moderation in therapy with Latino clients.

Several techniques were reported to help the therapist to deal with the language barrier. First, efforts should be made to maintain Spanish-language skills outside of the therapy session. Those skill-building techniques that involved dialogue with other people, and that enriched the cultural understanding of the clinician were seen as the most beneficial. These included speaking with colleagues, family members, or friends in Spanish, and watching the news in Spanish.

Second, the participants in this study spoke about “the language groove” which was reachable through consecutive Spanish-language-client contact. For a clinician whose case load was mixed between Spanish- and English-speaking clients, this was accomplished by scheduling their Latino clients in clusters. This enabled the therapist to get into a groove of speaking Spanish. It also avoided the fatigue inherent in switching between languages from one hour to the next. The same “language groove” effect was
also attained by maximizing the amount of Spanish-speaking clients in one’s case load. The therapist was forced to keep in practice, and their bilingual therapeutic muscles were protected from atrophy.

Lastly, the bilingual therapist should consciously focus on tracking the non-verbal communications of the clients. It is inevitable that there will be difficulties in both expression and comprehension when doing therapy in a second language. Non-verbal communication is important in all kinds of therapy, but it is especially important when the relationship is potentially hampered by a language barrier. Focusing on non-verbal behaviors enables the therapist to track unspoken cues and communications that can help to fill in the gaps left open by the language difference. When asked if he did anything differently to communicate empathy to his Spanish-speaking clients, Subject 1 stated “I tend to sort of … respond to … their … reactions.” As reported above, most of the participants in this study reported tracking the non-verbal behaviors of their clients more closely than they do in English, as a means of neutralizing the potentially debilitating effects of the language barrier.

**Authority**

The final implication for clinicians addressed the power differential that is often present in bilingual therapy. As was discussed above, the bilingual therapist is placed in a position of increased authority over his/her clients. Latino clients are naturally predisposed to submitting to the authority of the professional counselor (Sue & Sue, 2003; Sue & Morishima, 1982; Szapocznik, Sanisteban, Kurtines, Hervis, & Spencer, 1982; Vontress, 1976, 1981). They are grateful they have found a therapist that speaks their language, and it is easy for the clinician to feel that they are doing a great charity for
the Latino population by struggling through therapy in a second language. The danger of this is that the process could rapidly devolve from therapy to therapist self-fulfillment. The therapist must make a conscious effort to avoid this pitfall and focus on maintaining an ethically-appropriate non-directive stance to ensure that his/her Latino clients are afforded the same therapeutic opportunities his/her English speaking clients are.

Limitations of Study

Although great care was taken to ensure the methodological integrity of this project, five limitations were identified for this study. First, all of the participants were members of the LDS Faith. A larger and more diverse sample would provide data that could be extrapolated to the general population. No biases were observed as a result of the religious faith of the participants, but it is difficult to know what subtle variations the factor had on the therapists’ experiences.

A more difficult demographic pattern to correct would be the ethnicity of the participants. Each of the participants in this study was Caucasian. When selecting therapists that speak Spanish as a second language, the researcher expected that the majority of therapists would be Caucasian, but the sample ended up being more homogeneous than was hoped. It would be interesting to see how the perceived cultural differences would change with other minority Spanish speakers, including Latino therapists who learned Spanish later in life.

Another incidental weakness of the study sample was that all but one of the interview subjects was male. Having more female interview subjects would have enabled the researcher to look for more gender-specific effects on the experience of the Spanish-speaking therapist.
In the transcribing phase of the data collection process, the undergraduate assistants who had volunteered to complete the transcriptions withdrew from the study. Due to time restraints, the research team was forced to transcribe the interviews themselves. The interviews were divided up between the researchers and transcribed individually. It is possible that the researchers were biased to the information they were exposed to in the transcription. This possibility was addressed in the coding process by ordering the analysis of each interview to ensure that the interviews they transcribed were not the first ones they coded. There were no visible effects of the transcription process on the coding of the interviews, but the researcher recognizes that unseen biases still may have existed.

The final limitation of the study stems from the personal experience of the lead researcher practicing therapy in Spanish. The researcher’s motivation for conducting this study became a possible interference as the study progressed. This was addressed in several ways over the duration of the study. First, the lead researcher was careful to follow the interview protocol stringently during the interviewing process. The participants were asked neutral, open-ended questions and were not consciously influenced in any way. Second, the research team was included in every aspect of the analysis process. The researcher’s potential bias was countered by three other researchers who were looking at the data. The researchers each came from different clinical, academic, and social backgrounds which enabled them to monitor and challenge each other’s potential biases.
Implications for Future Research

This study illuminated several areas in which bilingual clinicians can improve their experience and competency in their second-language work. Several areas of improvement were identified that could further our understanding of the experience of the second-language clinician, and further the field of multicultural therapy. Four central implications for future research were identified.

First, this study provided a methodological framework for subsequent studies that can seek out larger, more diverse samples, and that can employ quantitative research methods to test the findings of this study.

Second, future research on this topic should be broadened to include therapists working in languages other than Spanish. Such a design would aid in the isolation of the effect of language on the therapists’ experience by enabling the researcher to control for cultural effects.

Third, the findings of this study would have been strengthened by accompanying outcome measures to determine the effect of various coping mechanisms on the overall therapeutic effectiveness of the therapist. In this way the gap between perceived and actual therapeutic effectiveness could have been bridged.

Fourth, the findings of this study would be best presented with concurrent client reports on the same subject matter. The addition of the client’s perspective would have lent further credibility to the findings, and would have served to triangulate the data to ensure its accuracy.

Conclusion
The development of culturally sensitive therapeutic techniques and modalities has never been more important than it is in this day and age. The Latino population is growing at a steady rate, and it is increasingly important that their mental health needs be met. Clinicians that are not only skilled in the language, but also well-versed in the culture can best accomplish this.

This study has highlighted some of the pertinent issues that must be addressed in order for the bilingual clinician to have a positive experience in therapy with native Spanish-speaking clients, and more importantly to be more clinically effective.

This study has identified several areas in which second-language Spanish-speaking clinicians can improve their bilingual practices. Future research should strive to confirm these findings through similar studies with the Latino clients with whom they have been working.

There is yet much to be learned about multicultural therapy, specifically when there is language barrier. With the aid of future research, Latino clients worldwide will be able to receive the competent and culturally sensitive services they require.
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Appendix A

Interview Protocol

Introduction

Thank you for agreeing to participate in this study. I am interested in your experience of doing therapy in Spanish as your second language. Specifically, I would like to know how you think language affects the therapeutic process. Would you like to start just by telling me what it has been like for you to practice therapy in a foreign language?

Follow-up questions

1. How did you learn to speak Spanish?
2. Are you of Hispanic decent yourself?
3. Are you in a relationship that operates predominantly in Spanish?
4. In what other settings in your life do you use Spanish regularly? How immersed are you in Latino culture and language?
5. How many years of experience do you have doing therapy?
6. On a scale of 1 to 10 how competent would you describe yourself as a therapist, 1 being a beginning level therapist and 10 being an expert therapist?
7. How many years of experience do you have doing therapy in Spanish?
8. On a scale of 1-10, how would you describe your level of fluency in Spanish, 1 being not at all fluent, 10 being completely fluent?
9. How does your competency as a clinician change when working in Spanish, as compared with your work in English?
10. Does the course of therapy change (for example longer or shorter sessions, longer or shorter term therapy) with Spanish-speaking clients than with English-speaking clients?

11. How would you describe the therapeutic alliances you build with your Spanish-speaking clients? Are these the same or different from those of your English-speaking clients?

12. How do you perceive language affecting the therapeutic alliance between you and your client, if at all?

13. Have you discovered anything to help the formation of the alliance in light of the language barrier?

14. How do you experience your Spanish speaking clients? Do you find them to be more or less expressive nonverbally? More or less demonstrative or cautious?

15. Are there areas of therapeutic intervention in which you feel more or less comfortable when working in Spanish?

16. Do you do anything differently to communicate empathy to your Spanish-speaking clients than with your English-speaking clients?

17. Does dealing with emotion when working in Spanish pose any special challenges? Tell me about them. How does this differ from working in English?

18. Are any areas of your clinical work are affected the most by the language difference? How do you handle these differences?
19. What has been your greatest challenge in doing therapy using a second language? Are there any other challenges doing therapy in a second language?

20. How does the language barrier change your therapy, if at all? What are the positive and negative effects of the language barrier?

21. Is there anything else you think would be helpful to me to know about your experiences in working in Spanish as a second language?

The following questions were posed by the research team and asked in a second round of questioning that took place over telephone with each subject.

22. If you were to do six hours straight of Spanish language therapy one day, and six hours straight of English language therapy the next, with identical clients, would there be a difference for you at the end of the day?

23. Do you find your clients to be more or less spiritual than your English speaking clients?

24. Would you agree or disagree with the following statement: Language is more important than anything else in therapy with Spanish speaking clients.

25. Do you find couples work to be significantly more difficult in Spanish than it is in English?