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¿*Me Explico*? Mexican Client Perspectives on Therapy With Spanish as a Second Language Clinicians

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Abstract

As globalization has exponentially increased social interactions across national lines, the need for bilingual and bicultural mental health professionals has logically followed. In this case study, we present exploratory phenomenological research conducted in Mexico in which we explored family therapy clients' perspectives on their experiences in therapy with non-Mexican Spanish as a Second Language clinicians. We discuss how nuances of language enhanced or hindered the therapeutic process with native monolingual Spanish-speaking Mexicans. The first author conducted interviews focusing on clients' perceptions regarding their therapeutic alliance, expectations, therapeutic outcome, and the influence of therapist's language abilities. We found surprising benefits to language differences such as facilitating culturally rich exchanges and increasing collaborative activity in therapy. We also discovered disadvantages linked to reduced mutual understanding. In addition, through the process of exploration in this topic, we encountered methodological and philosophical challenges which we discuss in detail in this case study.

Learning Outcomes

By the end of this case, students should be able to

- Not only understand but also define and articulate certain logistical challenges of conducting qualitative research with linguistically and culturally different people in an international context
- Learn and explain their own strengths and weaknesses of methodology and process as both researchers and therapists
- Describe how a researcher's native language, nationality, and cultural responsiveness influence results and limitations in international research

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Project Overview

As Spanish as a Second Language (SSL) Marriage and Family Therapy (MFT) students and aspiring social scientists, our research team became fascinated by a unique challenge we encountered as we accrued therapy hours in Spanish in Mexico City: the language differences between clients and us as therapists. As Master's students, we chose to study in Mexico to learn Spanish, eager to prepare ourselves professionally for the increasingly rapid globalization of the world. The first author of this case study, Jason Linder, narrates throughout our case and refers to himself in the first person "I." This case sheds light on our quest and struggle as we learned how to effectively bridge cultural and linguistic gaps between ourselves and our clients. We also consider our own growth as researchers and client participants, exploring how SSL

therapists working with Spanish-speaking Mexican clients can both enhance and hinder therapy.

Context

We live within a diverse multicultural and multinational global system that is increasingly interconnected in ways never before seen in our planet's history (Gallardo, 2014; Mittal & Wieling, 2006; Platt & Natrajan-Tyagi, 2014). An essential aspect of this global diversity includes an estimated 7,105 living languages (Paul, Simons & Fennig, 2013). Of the more than 7 billion people on our planet, it is estimated that the majority (1,197 million people) are first-language Chinese speakers, followed by Spanish, English, and Hindi majorities (Paul et al., 2013). Interactions between speakers of these and many other languages around the world are occurring on a daily basis, including between mental health providers and clients. In our age of globalization (Statista, 2016), it is important for mental health professionals to consider the implications of language differences and how a person's linguistic roots intersect with context. In our study, we aimed to better understand how SSL clinicians influenced clinical work with first-language Spanish speakers.

Psychology has recognized the need for therapists to address, in both training and practice, race (Laszloffy & Hardy, 2000; McGoldrick & Hardy, 2008), gender (Knudson-Martin, 1997), ethnicity (McGoldrick, Giordano, & Garcia-Preto, 2005), class (Laszloffy, 2008), and sexual orientation (Fish & Harvey, 2005). However, our field has only recently begun to widen its lens beyond the U.S. perspective and address nationality (McDowell, Brown, Kabura, Parker & Alotaiby, 2011; Platt & Laszloffy 2012; Platt & Natrajan-Tyagi, 2014). Language training will increasingly be not only relevant but also *central* in mental health training curriculums (Aguirre, Bermudez, Cardona, Zamora, & Reyes, 2005; Mittal & Wieling, 2006; Niño, Kissil, & Davey, 2016).

Although a few graduate programs have integrated Spanish language training into their curriculum, few opportunities for reflection of intensive language differences are available for family therapists (Platt, 2012). Currently, language training is considered supplemental, for therapists, but we believe it must become more central to training therapists. Clinicians today, though, are frequently in contact with clients whose first language is not English (Paniagua, 2013). The profound need for therapists to meet increasingly complex language-related needs already exists and will likely expand (Hoff & Core, 2015). As an MFT trainee, I was eager to develop international and linguistic skills to serve culturally different others and distinguish myself in the field. I was driven to conduct social-justice-oriented clinical work and research with underrepresented, while not always "minority," populations. Therefore, my decision to embark

on this research was timely and a personal step toward ensuring diverse communities is adequately served.

Previous research reveals language differences between clients and therapists do have clinical and training implications that need to be addressed in graduate programs (Santiago-Rivera, Altarriba, Poll, Gonzalez-Miller, & Cragun, 2009; Verdinelli & Biever, 2009). Namely, issues of bonding, feelings of restriction, fear of grammatical correctness, isolation, and disconnectedness can inhibit therapeutic processes. Aguirre et al. (2005) similarly concluded many bilingual therapists struggle to find the correct therapeutic words in Spanish when their education has been in English.

Research Logistics

The second author was the founder and director of the California Clinic: A Counseling and Dialogue Center based at Alliant International University's Mexico City campus, where I chose to carry out this research and therapy training. The clinic served as a training center for Master's level supervisees enrolled in an international counseling psychology program. Most clients seen at the clinic were monolingual Spanish speakers, whereas most of the student clinicians spoke Spanish as a second language and were at different stages in their command of Spanish. Prior research on language differences in clinical settings was conducted in the United States, and for our research, we were interested in the cultural and national nuances we might encounter in the Mexican context.

After graduating from this program, our long-term goal was to return to the United States to serve Spanish-speaking communities. Our intention was to better understand client's perceptions and experiences in their therapy with SSL speakers. We studied SSL therapists' strengths and weaknesses, as well as how language, culture, and nationality influenced clinical encounters. We purposely privileged clients' experiences as our main tool to understand their lived experiences and phenomenology. We specifically considered language and subtleties in the client/therapist rapport that would likely be overlooked and missed through other research methods.

Undoubtedly, it was an unmatched learning experience, especially regarding how much I still did not know and had to learn to be a successful therapist and researcher. Throughout my training and this study, my Spanish improved drastically, my cultural awareness deepened, and many of my clients reported their therapy with me to be helpful. Before conducting this research, I had no formal training in qualitative research methodology. For example, a few of the interviews ended prematurely because I did not know how to better elicit the participants'

relevant narratives. Despite my lack of experience, I had to remind myself constantly to trust that I could do it and that this research is timely and important. While I regret not better preparing for interviews, I notice that I challenged participants in a new way: to give their uncensored feedback to foreign people in positions of power, crossing cultural barriers that social customs usually advise against.

Research Design

First and foremost, we aimed to prioritize and privilege clients' lived experiences with their therapists, privileging culturally sensitivity. Because empirical research on cross-cultural therapy is extremely limited, we conducted our exploratory qualitative phenomenological study using semi-structured interviews with monolingual Spanish-speaking Mexican clients who were provided clinical services by an SSL non-Mexican clinician, including myself.

We submitted the proposal to our university's Institutional Review Board (IRB) on December 7, 2012, and it was approved in April 24, 2013. Over the next 4 months from May to August 2013, I interviewed my colleagues' clients, and they interviewed a few of my clients at our university's clinic. Three of the clients were from family therapy, six from individual therapy, and two from couple therapy. Demographics for the sample included 11 participants total—seven females and four monolingual Mexican males from Mexico City with an age range of 18 to 56 years and an average age of 37 years. Most of the clients are from low socioeconomic status (SES) areas within Mexico City with limited formal education. The average duration of family therapy for this sample was six sessions during the research interviews. Of the seven clinicians whose clients participated in this study, four were male and three were female. Five were from the United States, one was from Switzerland, and another from Kazakhstan. The clinicians ranged in age from 25 to 35 years; all the clinicians had been learning Spanish for a minimum of 2 years and were in their second year of their Master's program.

We conducted this research using a qualitative phenomenological approach, in which we used open-ended semi-structured interview techniques. A phenomenological approach emphasizes the subjective and narrative elements of human experience and is designed to give voice to often unrepresented client voices in family therapy research (Dhal & Boss, 2005), focusing on social justice (Lyons et al., 2013). Data were collected using open-ended interviews that averaged approximately 25 min. Interviews were brief, but they were focused on how language influenced the degree to which participants experienced a positive therapeutic alliance (Duncan, 2010; Martin & Garske, 2000; Sprenkle, Davis, & Lebow, 2009), client expectations (Duncan, 2010), the client's perception regarding therapeutic outcomes, moments or patterns when language-based misunderstandings occurred, and how the therapist's language skills in

general influenced their perceptions of the therapeutic process.

We analyzed our data using content and thematic coding, pattern finding, and member-checking with a few participants to confirm consistency of our initial themes. Authors collaborated to develop our themes and findings. The first author conducted a content analysis of the interviews to develop themes from the clients' responses, like what has been done in other studies (Morgan, 1993; Platt & Busby, 2009). Importantly, identified themes emerged through induction from the data as opposed to deductively from pre-existing constructs found in the literature. The first author did the initial content analysis of the interview data to develop preliminary themes, translating pertinent content from interviews from Spanish to English with the assistance of first-language Spanish-speaking clinicians at the clinic. To eschew unintentionally injecting personal biases, the second author then cross-checked the data to review the validity of the themes. If there were data that did not fit within the original themes, a new category was then created.

Results

Three overarching themes emerged regarding client's experiences in working with SSL clinicians. First, we found in many instances language difference was described as not an issue for clients. Second, language differences often had unexpected clinical benefits. Third, there were challenges and clinical difficulties associated with the language limitations of the therapists. This last theme, a less frequently reported but concerning one, was primarily about our clients not feeling understood or having difficulties understanding their SSL therapists.

Theme I: Language as a Non-Issue

Consistent with the research by Morris and Lee (2004), most participants in our study did not report working with a SSL therapist to be an area of significant concern. Rather, they reported that therapy with second-language Spanish speakers was largely a non-issue. Clients considered other variables, like the humanity of the therapist and their knowledge and clinical skills, to be more important. As a 22-year-old female client in individual therapy stated,

> My therapist sometimes mispronounces words or says things incorrectly but that's okay because therapy depends on the therapist, not the language he speaks in or the way he says it.

Similarly, an 18-year-old male in family therapy stated,

> A therapist's education, training and personality were much more important than language factors. My therapist was helpful. Language didn't have much of an effect.

A 25-year-old female in individual therapy explained further that

> A therapist's ability and effectiveness is way broader and more important than factors related to language alone.

The very fact that a clinician may have struggled with and felt anxiety about their language limitations may have led to them making additional efforts at communicating attentiveness. A 42-year-old female client discussed this complexity, stating,

> My therapist was very attentive and tried very hard to understand everything I said. Talking to her has helped me a lot and I still feel very understood by her even if her Spanish is hard to understand sometimes. Even though her Spanish was limited, her efforts to understand me were authentic, her spirit was authentic, and this made up for it. I love how she has been helping me.

Theme II: Language Negotiation and Clinical Benefits

Many clients described how the cultural dissimilarities between them and their therapists, with language differences being a component, were beneficial. Kissil, Niño, and Davey (2013) found similar results when looking at foreign-born therapists working in the United States. Their explanation is "because of their intimate experiences with at least two cultures and struggles making sense of and integrating multiple realities, immigrant therapists are in a privileged position to develop a meta-perspective about culture" (p. 139). This fit with several clients' reports of gaining new perspectives connected to nationality differences. Clients discussed how the process of negotiating language differences was valuable because it slowed down the therapeutic process. A 35-year-old female in individual therapy reported,

> Sometimes I had to be more specific, detailed, and concise in my responses which can be good because then, maybe it helps me understand myself better.

For other clients, language differences were experienced as part of a bicultural exchange they found useful. The opportunity to engage in a cross-national interaction was reported as being novel and exciting for the clients. The experience of being understood by a non-Mexican SSL clinician as a monolingual Spanish-speaking Mexican, especially if you had never met or interacted with someone from another nation, was experienced as an interestingly rich cultural exchange. A 39-year-old mother in family therapy mentioned,

> If our therapist spoke Spanish as a native language, communication would flow a little better but it would be more boring and less interesting.

A similar idea was conveyed by an 18-year-old male participant who also stated,

> I like that my therapist is from another county. It doesn't bother me that he doesn't speak Spanish too well because he brings interesting ideas and perspectives.

Clients described how the process of negotiating language barriers (and other cultural differences) created a source of new perspectives for them. For example, three different clients shared their appreciation for their clinician's viewpoint because it was more likely to be different from their own or another therapist's. A 39-year-old female participant reported valuing when her SSL therapist spoke of life in the United States with an "American accent" and how it compared with Mexico because she learned new and interesting viewpoints every session about how relationships might differ in the United States.

In Aguirre et al.'s (2005) study, Maria Bermudez, a bicultural and bilingual therapist, felt that struggling a little in her Spanish helped her take and maintain a collaborative approach with her clients and not assume or judge. In our study, several clients also reported working with SSL therapists to be positive because they perceived less hierarchy. For example, one participant reported it was refreshing to work with an SSL non-Mexican clinician because she did not experience the dogmatic and "machista" attitudes she had previously experienced in therapy. Another 18-year-old male in family therapy affirmed that he felt more understood by his therapist as his SSL therapist did not assume what he was trying to say or interrupt him mid-sentence. Two female participants were particularly pleased with each of their SSL clinicians, as they stated, "she followed their lead." A 19-year-old female just finishing family therapy with her mother said,

> Therapy was refreshing and useful because our therapist didn't judge me the way other therapists had in the past. My therapist listened to me in a different way, attentively and gave me a new point of view.

Although clients connected the collaborative nature of their interactions to the topic of language, we know that therapy in Mexico is traditionally conducted differently. In addition, our participants' comments also likely reflect a common tendency among some Mexicans to assume quality is higher in anything that comes from the United States and Europe (Batalla, 1996) because it represents high status (de Rios, 2014). Although it is positive that many clients were valuing their experience, comments like one from a 28-year-old male in couple therapy who stated that "It was like my therapist and I were on a team together and were engaging in a lot of teamwork, which was cool. It didn't feel like that with my previous Mexican therapist" also raise supervision and training issues around nationality and nationalism that need further

exploration and understanding.

Theme III: Clinical Barriers and Language Limitations

We noticed that the difficulties clients expressed around language limitations were often couched within a compliment. For example, a 42-year-old female participant reported,

> We work hard as a team to understand each other.

Another 34-year-old female participant reported,

> I sometimes have to change my wording so my therapist understands me but it doesn't bother me because we also make sure I'm understood and that is helpful.

A 39-year-old female in family therapy reported,

> I felt good when my therapist understood where I was going even if I had to repeat myself a couple times to get my words across.

Another 18-year-old female participant stated,

> Sometimes it was challenging because I had to be more attentive and "focused" to what my therapist was saying. If I missed anything, it was even harder to follow. However, this, I guess, is good for me because listening is important.

Although it is obvious that our program needed to continue to assist therapists who were improving their Spanish language competencies, it was not always clear when language limitations outweighed the benefits clients reported or exactly what level of language ability must be achieved. Other times, it was clearly problematic and evident that steps must be taken to address the clinical concerns. For example, an 18-year-old male in family therapy felt anxious, misunderstood, and frustrated because he could not understand his SSL therapist well. He explained,

> I have to pay a lot more attention to what my therapist is saying so I don't miss anything. Sometimes it was hard to understand him. I'm also not sure if he understood everything. When I would come in and was very anxious, my therapist not understanding me made it worse and made me more anxious.

Similarly, a 42-year-old female participant reported,

> Sometimes we have awkward moments that interrupt the therapy. What was he trying

to say?

Sometimes the language limitations of the therapist required the client to change their normal speaking pace and style. A 27-year-old female in individual therapy who tended to talk quite fast reported,

I have to consciously slow down my speech so my therapist could understand

Similarly, two participants (a 21-year-old female and 31-year-old male who were both in individual therapy) who tended to talk softly and quietly in therapy reported feeling the pressure to “speak up” and articulate clearer so that their therapist could hear and understand them.

Discussion

Our findings suggest that as SSL therapists, we are able to provide services that first-language Spanish-speaking clients value, although sometimes the value comes in unintended ways. They also suggest that foreign language competency for clinicians is far more complicated and layered than simply using grammatically coherent Spanish. The clients’ responses revealed how their perceptions regarding an SSL therapist’s language ability intersected with other factors such as nationality, culture, education, race, class, and socioeconomics. Perhaps non-verbal components of communication are an underestimated factor to consider in future conceptualization of language training and competency. Nonverbal aspects of communication also seemed to help carry SSL therapists through many language barriers, possibly compensating for with verbal aspects of communication.

That certain clients experienced challenges tied to the language limitations of SSL therapists calls us to reevaluate our current methods of assessing language abilities. In addition, that every single participant responded affirmatively to the question “How effectively were you able to work on everything you wanted to in therapy?” also raises the concern clients may have remained hesitant to provide critical feedback in interviews implied they avoided statements perceived as shaming their therapist. We are unsure as to whether participants felt safe to respond negatively. That the concerns that were expressed were often sandwiched within a compliment is consistent with research suggesting direct confrontation is often considered rude in Mexican culture, and therefore, many Mexicans communicate concerns indirectly (Batalla, 1996). This cultural tendency likely has relevance for our research.

Concluding Thoughts

[First author voice] Because this was my *first* research study, I was periodically riddled with self-doubt on two levels (as a researcher and therapist) that ran parallel to each other. Was I asking

the right questions? How do I get participants to provide more detail about their lived experience? How did I know therapy was helpful to clients just because they said it was? How did I know they were not just trying to be polite? Given the cultural penchant of deferring to people in positions of power and authority, how reliable and generalizable are my research questions and interviews? As both a therapist and a researcher, this study suggested many language-related issues I wanted to strongly consider as I returned to the United States to work with Spanish-speaking clients. We would also suggest readers interpret our findings with caution, as people usually seem to be satisfied with anything researchers inquire them (Gutek, 1978). Realizing that participants (as a researcher), as well as my clients (as a therapist), may have withheld information to save face and/or preserve our self-worth or professional role was frustrating, but we believe it was expected, given this study demanded we cross cultural barriers and bend social rules. In this sense, this study may have created more questions than answers. Perhaps some of the questions raised might also be useful for researchers and graduate programs, supervisors, supervisees, administrators, faculty, agency directors, staff, and other community members to consider along with us. In this spirit, we would like to end by offering a few initial informed dialogue prompts on language and mental health (see Table 1). Keep in mind that these prompts were not included in the interview protocol; the participants' responses themselves inspired these dialogue prompts. In the end, this study is merely a start. Our hope is that it inspires students to pursue multicultural and social-justice-oriented research agendas so that clinicians better serve, and researchers better understand, culturally different populations as the world becomes increasingly diverse.

Table 1. Dialogue prompts on Language and mental health.

Education, training, and supervision
1.How is language connected to culture and how might our multicultural and diversity training efforts better prepare clinicians to address this aspect of culture? 2.How might the issue of language diversity be better addressed in supervision? 3.What concrete steps can be taken, beyond merely taking language classes, to increase clinician's foreign language competencies? 4.What level of language ability should supervisors have to supervise clinical work in a second language? 5.How might learning a second language be linked to issues of social justice? 6.How can we know whether a clinician's ability in a second language is adequate for engaging in clinical work as a therapist? 7.Given that few therapists will learn many of the minority languages that exist, are there other ways to meet minority language speakers' mental health needs?

8. What educational structures do you think need to be in place to support second-language speakers' success in their educational and professional pursuits?
9. What are the ramifications of standardizing language learning and testing for this purpose? Or its implications for supervision?
10. What responses might we anticipate as training programs or supervisors initiate efforts to incorporate language learning into MFT training?

Self of the therapist and language

1. What experiences have you had in your life with different languages and how have those experiences informed your language views?
2. What are your honest reactions to and how are your listening abilities influenced when talking to someone who has a strong accent in your native language?
3. What *self of the therapist* issues arise for you as you attempt to learn and work in a second language (e.g., language privilege, emotional triggers, bias)?
4. How might factors such as race and skin tone influence how different languages are perceived?
5. What common themes or messages exist in your culture and community around foreign languages and how might these contexts influenced your views?
6. How might nationalism contribute to language barriers in mental health?
7. What might be some examples of micro-aggressions linked to language and how might these occur in clinical work?
8. How might we address the issue of xenoglossophobia (the fear of foreign languages)?
9. What intersections of power and privilege need to be considered around language (e.g., nationality) and how can problematic power differentials be best addressed?
10. If you speak a second language, how do you feel you are perceived when speaking that language?

Clinical practice and language

1. How do you think clinical work is influenced when clients must speak in a second language in therapy?
2. What emotional wounds or relational challenges do you think clients might bring into therapy that might be connected to the issue of language?
3. How can language differences between therapists and clients be used as a resource in clinical work?
4. What are the clinical implications of clients who have a bias for or against therapists with different accents?

5. What should therapists understand about clients when family members have differing language abilities (e.g., immigrant families, couples where the partners have different first languages, etc.)?
6. What are the clinical and ethical implications of working with or without a translator?
7. How can non-verbal language abilities be used better within clinical work to bridge language barriers and cultural differences?
8. How might a therapist proceed if members of the same family differ on which language they would prefer to be spoken by the therapist and within therapy?
9. What techniques and methods can therapists draw on to negotiate meaning when language limitations exist?
10. What important questions about language should be added to this list that would be important for the field of family therapy to consider?
11. Mark Twain cautioned that "the difference between the almost right word and the right word is really a large matter—it's the difference between the lightning bug and the lightning" (Twain, 1888, p. 88). What are the implications of this when thinking about clinical work and SSL clinicians?
12. Given the complexity of language issues, how do we make sense of the numerous examples of gifted and effective therapists, such as Insoo Kim Berg and Salvador Minuchin, whose work has primarily been conducted in their second language?

MFT: Marriage and Family Therapy; SSL: Spanish as a Second Language.

Appendix

General Guide for Semi-Structured Open-Ended Interview

1. Description of the therapeutic process.
2. What were the benefits or challenges of having a Spanish as a Second Language (SSL) therapist?
3. How was the therapeutic experience for you? How effectively were you able to work on everything you wanted to? (Miller, Duncan, Brown, Sparks, & Claud, 2003)
4. How did your therapist's level of Spanish influence your relationship with him or her? How did your therapist's level of Spanish influence your expectations for the therapy?
5. Given your therapist's level of Spanish, how would you evaluate your therapy on the whole?
6. How well did you feel heard and understood? (Miller et al., 2003) How well did you understand your therapist?
7. What aspects of the therapy would be different if the therapist spoke native Spanish?

8. Regarding the influence of language, what was particularly helpful or unhelpful?
9. Are there any other questions I should ask you? For example, what haven't I asked you yet, as I'm not in your situation?
10. Any other general statements you would like to make regarding the influence of language in your therapy?

Exercises and Discussion Questions

1. What emotional wounds or relational challenges do you think research participants, as well as clients, might bring into therapy that might be connected to the issue of language?
2. Reflect on how language factors can influence the research process with diverse populations.
3. How can language differences between researcher and participant be used as a resource in research?
4. What are the implications of research participants who have a bias for or against researchers with different accents?
5. What are the practical and ethical research implications of working with or without a translator?
6. How can non-verbal language be used within research to bridge language barriers and cultural differences?
7. What techniques and methods can researchers use to negotiate meaning when language limitations exist?

Further Reading

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