The experience of working as a therapist when English is not your first language: an interpretative phenomenological analysis.

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The candidate confirms that the work submitted is his/her own and that appropriate credit has been given where reference has been made to the work of others.

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Abstract

Multilingualism is now considered to be the norm rather than the exception across the globe (Bialystok, 2001). Research about multilingualism has shown that self (Marcos & Urcuyo, 1979), memory (Scharuf, 2000) and emotion (Caldwell-Harris & Ayçiçeği-Dinn, 2009) are all experienced differently for multilingual individuals depending on the language they are speaking. These facets of psychological functioning are also important in managing reactions as a therapist and developing a therapeutic relationship with a client. The last in particular has been seen as an important contributor to positive therapy outcomes (Norcross, 2010). There are few national data available showing the languages spoken by regulated therapists in the UK. The present study was designed to explore these issues further. Firstly, a web-based survey was completed by 101 multilingual therapists nationwide. Within the sample of respondents, 30 countries of origin and 39 languages were represented. Subsequently, six participants were selected to take part in semi-structured interviews. The interview transcripts were analysed using Interpretative Phenomenological Analysis. Two sets of results are presented. This first focuses on experiences of delivering therapy in English as a non-native language. Three levels of themes were identified. The first consisted to two master themes: *Feeling challenged* and *Feeling equipped*. The second level consisted of three main themes: *Feeling accepted in the workplace, Achieving a sense of robustness in therapy* and *Achieving a sense of competence in therapy*. Each master theme had two sub-themes, which completed the third level. The second set of results is based on the experiences of delivering therapy in a first language having trained in English. Three themes were identified: *Feeling awkward and less confident, Feeling a greater distance from the client* and *Developing cultural dexterity*. The themes are discussed in relation to wider psychological literature. Strengths and limitations of the study are noted, and recommendations for clinical practice and future research made.

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Introductory overview

At the age of 11 I was on a family holiday in a restaurant off the beaten track in Andalucía. The waiter spoke no English, and as he read out the specials and my family tried to decipher what was on offer, I heard a word: *conejo*. Shocked I had understood something from my Spanish classes at school, I began persuading my family that the special of the day was rabbit. I remember a huge sense of satisfaction and there began my fascination with multilingualism. At the age of 18, I went on to live in South America and Andalucía for four years. I taught English and during summers worked in shops and bars using my English and Spanish. Languages continued to fascinate me. However, something else had also caught my attention; Clinical Psychology. Having returned to the UK, I began to learn about, and work with, psychological theory, therapies, people's emotional experiences and their psychological worlds. I began to read about multilingualism in therapy and was intrigued by this area of literature that brought together two of my interests. I came across the therapy case of Anna, of whom her analyst wrote,

> *"In English, her second language, she is strong, brave, and independent. In Spanish she is her mother's frightened, dependent child" (Perez Foster, 1992, p.70).*

It seemed that language altered both her experiences of self and of emotion and this formed a key role in her therapy. It made me think about my own experiences of self and emotion in Spanish and English. I knew that experiences of both self and emotion were cited in the literature as important considerations for psychological therapists, and experiences of both were different for people who were multilingual depending on the language being used. I began to think about what it might be like working as a therapist in a non-native language based on these ideas and the more I thought about it the more it seemed to be an important clinical issue that was both interesting and worthy of investigation. My curiosity about this became a professional interest, which then developed in a set of research questions. This research project is my attempt to answer the research questions exploring what it is like to practise as a therapist in English as a non-native language.

Chapter 1: Introduction

1.1 Chapter overview

I start this chapter by considering definitions and prevalence of multilingualism. I then present a literature review focusing on multilingualism and therapy, particularly when a therapist speaks more than one language, and practises in a non-native language. I then define the research questions of this project, before exploring some methodological considerations. I conclude by providing a brief overview of the study design.

1.2 Definitions and prevalence of multilingualism

Definitions of multilingualism

Defining multilingualism is complex (Santiago-Rivera & Altarriba, 2002). The larger majority of research focuses on bilingualism specifically, which is much more familiar in the literature (Harris & McGhee-Nelson, 1992). Weinreich (1953) defined bilingualism as "the practise of alternately using two languages" (p.5). However, this definition appears to overlook a distinction highlighted by Ervin (1961). She put forward two definitions of bilingualism; a compound bilingual and a co-ordinate bilingual. A compound bilingual is a person who grew up using two languages simultaneously and has one representational meaning for an object that can be accessed in both languages. Meisel (2005) suggested that simultaneous acquisition of bi/multilingualism occurs "if the child begins to acquire two or more languages during the first three or four years of life" (p.105). On the other hand, a co-ordinate bilingual typically learnt one language first and then went onto learn another after infancy, often through socialisation in another culture (Scharuf, 2000). In short, it is proposed that compound bilinguals have two languages organised in a single cognitive system, whereas co-ordinate bilinguals have their languages organised in separate systems. It has also been suggested that this is best viewed as a continuum and not a dichotomy (de Zulueta, 1984). Further definitions come from

de Zulueta (1984) who stated that a 'balanced' bilingual is one who has native proficiency in both languages, whilst a 'dominant' bilingual would have greater fluency in one language. Connolly (2002) claimed that bilingualism is "the capacity of an individual to express himself in another language and to adhere faithfully to the concepts and structures of that language rather than paraphrasing his native language" (p. 370). However, she went on to use the terms *polylingual subject*, referring to an individual who has learnt more than one language from birth and *polyglot*, who acquires different languages at different stages of development.

The complexity of defining multilingualism is further highlighted by the taxonomy of eight categories put forward by Gass & Glew (2008): Native Speaker, Near-Native Speaker, Advanced Language Learner, Heritage Language Speaker, Second Language Learner, Second Language Speaker, Bilingual and Multilingual. It would appear that this complexity comes from the many variables at work in becoming multilingual, such as age at acquisition, form of acquisition, history of use, degree of proficiency, degree of dominance, cognitive organisation, social and emotional factors and the linguistic relationship between the languages. Moreover, Guttfreund (1990) pointed out that individuals may have different levels of proficiency in different languages across different contexts. It is therefore unsurprising that Hamers & Blanc (2000) claimed that definitions in the literature lack precision and operationalism. They went on to offer the following definition: "the psychological state of an individual who has access to more than one linguistic code as a means of social communication" (p. 6). It is this definition that will be used when referring to multilingualism henceforth. Although more general than the other definitions, it has been chosen as it encapsulates the many different types of multilingualism discussed in the literature and does not seem to prioritise or exclude any of the variables which impact on becoming multilingual. When describing the research of other investigators, I aim to use their terminology as closely as possible. Many researchers use the term *second language*: I have favoured, however, the term *non-native language* to address assumptions about, for example, the number of languages spoken and the order of acquisition. I use the term *first language* to refer to the language that was acquired first.

Prevalence of multilingualism

Given the complexity in defining multilingualism and the many forms it may take across the globe, no precise statistics exist (Grosjean, 2001). However researchers are converging on one point: that across the world it is now the norm rather than the exception (Harris & McGhee-Nelson, 1992; Bialystok, 2001). Indeed, Grosjean went as far as to say that "In fact it is difficult to find a society that is genuinely monolingual" (p. 1). Crystal (2003) estimated that two-thirds of children worldwide are brought up in an environment where more than one language is used and that over 40% of those who speak English in the world are bilingual in English and another language. In the UK, it was estimated that 350 minority languages are in routine use (Crystal, 2007). Multilingualism is becomingly increasingly common in the UK, partly as a result of the formation of the European Union allowing greater mobility between countries, as well as immigration (Baker, 2006). The 2011 UK census gathered information on language spoken in the UK, following calls from health care professionals (Aspinall, 2005, 2007). Results showed that 4.2 million people (8% of usual residents in the UK) had a language other than English. In London, this figure rose to 22%, representing 1.7 million people. The second most reported language was Polish, followed by Panjabi and Urdu. Of the 20 most reported languages, five were South Asian languages and nine were European (ONS, 2013).

There are few data available regarding the prevalence of multilingual therapists, although anecdotal evidence suggests that there is an increase (Morris & Lee, 2004; Akhtar, 1999). Indeed, an increase may be expected, given two European initiatives. Firstly, the European Certificate in Psychology (EuroPsy) from the European Federation of Psychologists' Associations (EFPA) facilitates the recognition of psychologists' qualifications in other European countries (EFPA, 2011). Secondly, in January 2011 a consultation paper was released by the European Commission as part of the Public Consultation on the Recognition of Professional Qualifications Directive (European Commission, 2011). It is likely that this will facilitate the mobility of healthcare professionals, including many psychologists working as therapists across Europe.

The British Psychological Society (BPS) state that multilingual, 'mother tongue' or first language data are not kept as they are not requirements for membership (BPS, 2011; personal communication). The Annual Report for the BPS shows that the number of foreign affiliates has increased by 207% since 1970 (BPS, 2009), although 'foreign' does not equate with multilingual. In order to appear in the BPS's Directory of Chartered Psychologists all entrants must demonstrate proficiency in English. However, a brief review of the directory shows that 26% also offer services in a language other than English (BPS, 2010). However, this includes academic psychologists and so does not reflect the national picture of multilingual chartered psychologists practising as therapists. Data on the languages spoken by members is not collected by the Health Professions Council nor the British Association for Counselling and Psychotherapy (HPC, 2011; BACP, 2011). In 2010 The Clearing House for Postgraduate Courses in Clinical Psychology began to monitor data on applicants who have English as a non-native language and those who speak languages other than English. Despite enquiries to establish the prevalence of multilingual applicants for clinical training, no data were available.

In 2010 the UK Council for Psychotherapy (UKCP) began to collect 'mother tongue' or first language data of its members (UKCP, 2010) and Costa & Dewaele (2012) suggest that 18% of those registered with the UKCP can deliver therapy in more than one language. Costa & Dewaele (2012) went on to carry out a web-based survey which was completed by 101 therapists, 83 of whom were multilingual. The sample consisted of 19 monolinguals, 30 bilinguals, 22 trilinguals, 20 quadrilinguals, and11 pentalinguals. Although not all the respondents were residents in the UK, within the sample there were 24 different first languages and 20 different nationalities represented. English was the most common first language. The authors present little data on the different languages spoken. The authors did not collect data on the languages in which respondents completed their training nor self-report measures of proficiency in different languages. The demographic data collected were a precursor to a Likert scale survey exploring the differences between monolingual and multilingual therapists. I will discuss the results in greater detail below.

Costa & Dewaele's (2012) study, along with data collection practices of the UKCP and The Clearing House for Postgraduate Courses in Clinical Psychology represent an emerging interest in addressing the lack of clear data of the prevalence and language profiles of multilingual therapists across the therapy professions. At present it is particularly unclear what proportion of multilingual therapists practising in the UK have trained in their first language or a non-native language and there is little data about the proficiency of the languages of multilingual therapists. Moreover, although the data presented by Costa & Dewaele's (2012) from the UKCP suggests that 18% *can* deliver therapy in more than one language, this does not clarify whether they actually have done so. As such it may be important to address some of these gaps in the data of multilingual therapists.

1.3 The focus of the literature review

There is a large amount of literature that covers the wide and multiple aspects of multilingualism. For this reason it is important to specify the boundaries of the literature review. The general focus of the current review hones in on the literature of multilingualism in therapy. This decision was taken for various reasons. Firstly, it was hoped that this would provide a general picture of directly relevant literature for a wide range of practising psychological therapists with different training backgrounds and an interest in multilingualism in therapy. Secondly, the search strategy (Appendix I), on which the review is based, is rooted in the basic concepts of the research questions (multilingualism and psychological therapists) as specified in the recommendations on systematic literature searches (Cochrane Collaboration, 2009) and literature reviews in qualitative research (Shaw, 2010). Thirdly, the aim was to develop an argument and justification for the study, as specified as the aim of a literature review (Rudestam & Newton, 1992). However, before proceeding with the literature review, I aim to briefly indicate other texts and literature that represent related areas of research, but that fall outside of the focus on multilingualism and psychological therapists.

For the reader interested in the literature on developmental perspectives of early life multilingualism, Paradis (2007) provided a helpful review of the literature of the

acquisition of more than one language in children. Deficit models of multilingualism suggested that to learn more than one language in childhood is detrimental for IQ and social adjustment (Saer, 1923; Anastasi & Cordova, 1953), but this has been challenged by findings suggesting that is not the case (Pearl & Lambert, 1962). For a more recent perspective, the reader is signposted to Luk, de Sa & Bialystok (2011) who concluded that growing up with more than one language brings cognitive advantages later in life, compared with monolingual individuals, such as increased language proficiency and cognitive control. Across the field there remains debate about the critical period hypothesis (Lenneberg, 1967), which suggests that language learning will be much more difficult outside a specific period in childhood and this was discussed in greater detail by Abrahamsson & Hyltenstam (2009).

For those with an interest in multilingualism later in the life span, Robinson & Ellis (2008) explored cognitive understandings of adult second language acquisition, whereas Ellis & Widdowson (1997) provide an educational perspective. Neurolinguistic contributions from Gullberg & Indefrey (2006) and Meuter (2009) provided an overview of having more than one language in adulthood and the ways in which more than one language is stored and processed in the brain, respectively.

Literature relating to identity and language in general may be of interest. Wetherell & Maybin (1996) provided an introductory text, whilst Peirce (1995) offered a more specific focus on the role of social context and how this impacts on identity during the acquisition of a new language. From a multilingual perspective, Pavlenko & Blackledge (2003) provided a comprehensive overview of understandings of identity in this specific context. A further issue that could be of interest is that of migration and its relation to identity in Britain and elsewhere (Benmayor & Skotnes, 1994; Julios, 2008). This also relates to research in which qualitative approaches are used to explore the experiences of living outside one's country of origin and within new languages and cultures (Skuza, 2007; Bagnoli, 2007).

The role of delivering therapy across different cultures will not be explored within the literature review. This decision has been taken to try and keep the focus on multilingualism and languages in therapy and to be able to explore the highly

relevant literature in sufficient detail. However, useful texts on therapy across different cultures include Kareem & Littlewood (1999), D'Ardenne & Mahtani (1999) and Lago (2005). I will now go on to present the literature review focusing on multilingualism and therapy.

1.4 Literature review

The review is presented in two parts. The first explores facets of psychological functioning which were identified as important in both the literature of client multilingualism and the general psychological literature of multilingualism: self, memory and emotion. The relevance of these issues is highlighted based on literature which explores self, memory and emotion in therapists in general. The second part of the review examines the methodologies and findings of literature which focuses specifically on the experience of multilingual therapists.

1.4.1. The relevance of self, emotion and memory for multilingual therapists

1.4.1.1 Self

In early psychoanalytic case studies, there were reports of clients experiencing and perceiving themselves differently according to the language spoken (Buxbaum, 1949; Greenson, 1950; Krapf, 1955) with an illustrative example from a patient of Greenson: "In German I am a scared, dirty child; in English I am a nervous, refined woman" (p.19). Similar conclusions were reached in clinical papers written by Marcos, Eisma & Guimon (1977) and Marcos & Urcuyo (1979) whose multilingual therapy clients reported different senses of self depending on the language used, each accompanied by different feelings and thoughts. Marcos & Alpert (1976) suggested that for multilingual clients, each language is related to different ego ideals, reflecting how the client would like self to be. Following a selective review of the psychoanalytic literature, Pérez Foster (1992) concluded that for clients who are bilingual a duality may exist that organises experience of the world and self. Burck (2004) has also commented on multilingualism and experience of self in relation to therapy, drawing on her research of people living in different languages. She indentified that people had different experiences of self in different languages,

including different experiences of subjectivity and identity. This literature seems to be summarised succinctly by de Zulueta (1990) when she wrote that "people can perceive themselves and their world in a different way depending on the language they speak or think in" (p. 264).

Different experiences of self across languages can be linked to the principle of linguistic relativity (Vygotsky, 1986) which predicts that the structure of language will determine thought processes and organisation. As such, thought processes and perceptions are different in different languages due to varying linguistic properties. Although alternative theories have been offered on the relationship between thought and language, such as Piaget (1926), evidence for linguistic relativity has been found in numerous empirical studies. These studies highlight that perceptions and thought processes differ, depending on language, in European samples (Boroditsky, Schmidt & Phillips, 2003) and when comparing equatorial African and English samples (Roberson, Davidoff, Davies & Shapiro, 2004). This suggests that for those who are multilingual, experiencing self as different across languages may depend on how different languages impact on perception of self.

The general therapy literature suggests that understanding and awareness of self is a key component of being a skilled therapist (Jennings & Skovholt, 1999) and as the most important factor in developing a therapeutic relationship (Baldwin, 2000). Combs, Avila, & Purkey (1978) put forward the concept of "self-as-instrument" meaning that the therapist can use their "self" as a clinical tool and research findings suggested that, for trainee therapists, having a certain level of awareness of self in therapy was helpful for therapists as well as clients (Fauth & Nutt-Williams, 2005). If self is experienced differently across different languages, and is also an important element of developing a therapeutic relationship (which in turn has been highlighted as a key for positive therapy outcomes (Lambert & Bergin, 1994; Wampold, 2001)), then therapists who are multilingual and practise in different languages represent an important area of research. The large majority of the literature focusing on therapist self does not take into account multilingualism and, furthermore, there may be important, as yet, unexplored issues relating to therapists' experiences of self across

languages in therapy that may be helpful for multilingual therapists as well as monolingual therapists.

1.4.1.2 Emotion

There are numerous case studies in the literature involving multilingual clients who struggled to experience emotion when retelling important life events in a non-native language, or showed little emotional involvement or limited affect and only manage to resolve difficulties about important life events and feelings once they have been spoken about in the language of early experiences (Buxbaum, 1949; Greenson, 1950; Krapf, 1955; Pérez Foster, 1992; Aragno & Schlachet, 1996; Clauss, 1998; Connolly, 2002; Favero & Ross, 2003; Conci, 2010).

Psychological research indicates that there is an important relationship between multilingualism and the experience and intensity of emotion. For example, Anooshian and Hertel (1994) administered an unexpected recall test to 36 co-ordinate bilinguals and found that more emotion words were recalled in the first language than the language acquired later in life. Furthermore, talking about embarrassing topics and saying taboo words provoked more anxiety in a first language compared to a second language (acquired later in life), and it appeared less anxiety provoking to discuss embarrassing topics in a second language (Gonzalez-Reigosa, 1976; Bond & Lai, 1986). This phenomenon has been seen in numerous language combinations, including German-English, Cantonese-English, Turkish-English and Italian-English (see Ramos-Sanchez, 2007).

When examining emotion and lying in a second language, Caldwell-Harris & Ayçiçeği-Dinn (2009, p. 202) found that “Bilingual speakers experience different levels of emotionality in their two languages...using both self-report and electro-dermal monitoring. Ratings and skin conductance responses (SCRs) were attenuated for hearing emotional stimuli presented in a second language”. Santiago-Rivera & Altarriba (2002) hypothesised that emotion words in a first language are encoded more deeply and as such have more traces in memory and a stronger semantic representation. Consequently, when a particular emotion word is encountered, more associations are activated in the first language, and a stronger emotional reaction is

experienced. By considering together the therapy case studies and the psychological literature, it seems that the use of a language in therapy, other than the language in which important events occurred, could have a considerable impact on emotional expression and experience in the therapeutic setting.

This findings seems important when considering the role of therapists' experiences of emotion in therapy. Kimerling, Zeiss & Zeiss (2000) suggested that it is important for a therapist to note both positive and negative emotional reactions to clients in therapy as this information is always relevant. They also suggested that more effective therapy will result from a therapist's sensitivity to his or her emotions. In some psychodynamic models emotional reactions in therapy have been referred to as countertransference. The phenomenon has also been examined from a cognitive perspective (Rudd & Joiner, 1997) and a humanistic-experiential perspective (Gelso & Hayes, 2007). Hayes, Gelso & Hummel (2011) suggested that countertransference is important in therapy and is inevitable because "all therapists, by virtue of their humanity, have unresolved conflicts, personal vulnerabilities, and unconscious "soft spots" that are touched upon in one's work" (Hayes, Gelso & Hummel, 2011, p. 89). Following a meta-analysis, they found that the successful management of countertransference is related to improved therapy outcomes.

Hayes, McCracken, McClanahan, Hill, Harp, & Carozzoni, (1998) suggested that a therapist's use of self as a therapeutic instrument can be greatly influenced by countertransference and that these emotional experiences of the therapist can help deepen his or her awareness of dynamics thus provide important clinical information. Different emotional experiences in different languages and the importance of therapist emotions suggest that it would be significant to explore emotional experiences for therapist practising in a non-native language. Without this, the literature may be lacking important considerations for those practising in non-native languages, for their supervisors and for their trainers. Moreover, it may be that useful findings could help illuminate our understanding of therapist experiences of emotion in general.

1.4.1.3 Memory

The therapy literature has numerous examples of early experiences and autobiographical memories being accessed or experienced differently in a non-native language. Buxbaum (1949) presented two cases of bilingual clients and concluded that the important childhood memories only became accessible when spoken about in the language in which they occurred and that "verbalizing experiences in the language in which they occurred makes them become real; speaking of them in any other language renders them unreal" (p. 286). Buxbaum and her contemporaries (Greenson, 1950; Krapf, 1955) conceptualised this phenomenon as a repression, with the non-native language acting as a defence mechanism against anxieties associated with these early experiences.

Through examination of experimental psychology literature and psychoanalytic case studies, Schrauf (2000) concluded that, in therapy, childhood memories are retrieved in more detail and with more emotional feel in the language of childhood, thus supporting what is known as the "mother tongue bias". Although not specifically relating to clients in therapy, Schwanberg (2010) examined the retrieval of trauma memories in co-ordinate bilinguals via a repeated measures design with a small sample (19), who had experienced trauma in childhood. This seems relevant given the role trauma may have for a client in therapy. She found that memories of trauma in the first language (the language of childhood) fulfilled the characteristics of a traumatic memory according to structured trauma assessments, more than in the subsequently acquired language.

In the 1970s and 80s, empirical research within the discipline of cognitive psychology found that language affects autobiographical recall. Findings suggested that for bilingual individuals, specific language cues activated memories in that language (Bugelski, 1977). Marian & Neisser (2000) also found that the principle of encoding specificity (suggesting that recall is facilitated when contexts at encoding and retrieval are the same) holds true in the recall of autobiographical memories and they concluded that language choice will influence both recall and interpretation of life events. This language congruity has been identified as the mechanism behind improved recall of early memories in the language used in early childhood (as

opposed to the psychoanalytic notion of repression and defences) by Aragno & Schlachet (1996), who hypothesised that this phenomenon is due to mental organisation, not defensive forces, and that experiences encoded in one language cannot be re-coded in another regardless of linguistic proficiency. By using monologues about dramatic personal experiences from co-ordinate bilinguals and dissecting the accounts into linguistic units, Javier, Barroso & Muñoz (1993) found that when recall happened in the first language, accounts were more detailed with greater emotional texture and more imagery. Similar conclusions have been reached by Marian & Neisser (2000) and Schrauf & Rubin (1998). The findings in relation to memory across different languages again seems to support conclusions from therapy case studies involving clients who are multilingual.

The relevance of memory retrieval across languages for multilingual therapists relates to countertransference. In their integrative definition of counter transference, Hayes, Gelso & Hummel (2011) suggested that the origins of therapists' emotional reactions are developmental in nature and usually traceable back to the therapist's early experiences (although oversimplification should be avoided). Similarly Springman (1986) highlights the importance of the relationship history of the therapist in their countertransferential reactions. Countertransferential phenomena in therapy, related to the early experiences, have also been explored in terms of neuropsychology. Research has shown that early experiences and enduring attachment styles are neurally encoded (Siegel, 2001) and early implicit learning can be triggered and identified in psychotherapy through neuroscience (Ginot, 2007; Fuchs, 2004). This means that a therapist's early experiences and ways of relating to people, and the associated emotional experiences, can all be triggered in therapy, and therefore should be considered to ensure that therapy is as effective as possible.

Although countertransference does not refer to explicit recall of childhood memories or experiences, it does suggest that there is a theoretical connection between childhood, past experiences, and emotional reactions in therapy. Again, it seems that those who are practising therapy in a language which is not their language of early experiences represent an area of research that is potentially significant as one distinct from those who practice in the language of their infancy. This is particularly the case

if we are to accept the assumption that the majority of literature and theory is based on the latter group.

1.4.2 Experiences of multilingual therapists

I will now move on to discuss the extant literature on the experiences of multilingual therapists. Initially I focus on the literature which explores general experiences of practising as a multilingual therapist. I will then move onto the experiences of multilingual therapists when the language used in therapy is specified as a non-native language for the therapist but not for the client. Within each section and where relevant, I will deal with clinical papers (which are largely psychoanalytic) and/or anecdotal evidence first, before exploring more systematic studies.

1.4.2.1 Practising as a multilingual therapist

Clinical papers and anecdotal evidence

In an analytic case study, Perez-Foster (1992) explored her spontaneous use of Spanish in analysis that had largely taken place in English with a client who had Spanish as a first language. She suggested that, unconsciously, she used Spanish as a way to facilitate the client making emotional connections with developmental material from her childhood in Spanish. Despite this she offered no reflection on her own experiences of working as a bilingual therapist. For Clauss (1998), Spanish was the language of her childhood although she trained in English. Through general reflection, she described her experiences of therapy in Spanish, which she found as more chatty and jovial compared to English. She experienced herself as more animated in Spanish and attributed this to a different intonation and use of humour in the Hispanic culture. Although she did not elaborate, she wrote that she sometimes felt especially skilled when working in different languages, whilst at others she felt 'out of sorts' as she confused languages at times.

Biever, Castaño, de las Fuentes, González, Servín-López, Sprowls, & Tripp (2002) highlighted the fact that there was very little literature to inform the training of Spanish-English bilingual therapists. Drawing from anecdotal evidence of working with trainee psychologists who were training in English but practised in Spanish in the USA, the authors highlighted some of the issues that can emerge for this sub-

group therapists. Bilingual trainee psychologists reported focusing more on using the language correctly, rather than on therapeutic issues. The authors also reported concerns from trainees and supervisors about a lack of formal language skills when discussing clinical work in Spanish. A key message was that having conversational skills in a language does not mean that a therapist can transfer this to professional knowledge and skills in therapy. Within the group of trainee bilingual therapists of their study there appeared to be a heterogeneity in terms of the 'type' of bilingual (compound or co-ordinate) and whether Spanish was a first or non-native language for the trainees.

Systematic inquiry from the USA

I have decided to present the research from the USA separately from that from the UK. This is because, on the whole, the research from the USA focuses on a very specific sub-group of therapists, English-Spanish bilingual therapists, working in a very specific context of a large Hispanic population. The dominance of this type of literature is likely to be due to the increasing Hispanic population in the USA (US Census Bureau, 2000; Saenz, 2004). As such, this is very different to the limited literature available from the UK on therapist multilingualism, in which the client and therapist do not share cultural, ethnic or language backgrounds.

Castaño, Biever, González & Anderson (2007) aimed to explore the challenges of delivering mental health services in Spanish by carrying out a 12 item questionnaire with 127 therapists who had trained in English but were practising in Spanish. Results showed that although 93% reported themselves as being conversationally fluent in Spanish, over half expressed concerns about translating technical terms and concepts in therapy and difficulty in producing written psychological reports.

In a qualitative investigation, Verdinelli & Biever (2009a) carried out a focus group with 15 Spanish-English bilingual therapists about their experience of supervision of Spanish-language services. Following phenomenological analysis, five themes were identified, with multiple sub categories. Within the theme *Language Issues*, was the category *Translating terms and concepts*, which referred to struggles with translating and communicating psychological theories and concepts in Spanish. A further

category under this theme was *Connection between language and emotions*, referring to different experiences of emotion depending on the language being used. An example given is being able to contain emotion more effectively in English (it is unclear if this particular participant learnt English from infancy or not). Themes also emerged around coping strategies. Within the theme of *Coping Strategy* was the category *Peer support and networking*. This referred to meeting with other Spanish-speaking professionals as an important way of coping. Within the sample of this study was a mix of ethnicity and bilingual types, including first generation Latinos, second-generation Latinos and non-Hispanic White Americans. Additionally, the authors acknowledged that this investigation was unable to answer the question of whether these experiences were different to those of monolingual therapists, as all therapists in the sample were bilingual so comparison was not possible.

Verdinelli & Biever (2009b) carried out telephone interviews with 13 bilingual English-Spanish therapists. Five were *Native Spanish Speakers*, the majority of whom were brought up in Latin America. The remaining participants were *Heritage Speakers*, meaning that they grew up in the United States, and either learnt Spanish at home and then English at school or learnt both concurrently. This group considered English to be their first language. Data were analysed using Phenomenological Analysis. The authors also found that practising in one language (Spanish), whilst receiving supervision in another (English) was found to be a challenge, which led to a trial and error approach to learning and self-teaching in Spanish. The majority of the participants expressed pride in being bilingual and providing services for the minority community. A theme was identified of *Self-awareness of language skills* as a therapist, and differences were reported between the two groups. When working with English-speaking clients, the Native Spanish Speakers reported paying more attention to speaking English correctly which distracted them from the therapy session. They also reported concerns about how their English-speaking clients and colleagues perceived them. The Heritage Speakers reported similar issues around feeling very aware of self in therapy sessions. They reported that increased self-awareness of their Spanish created misunderstandings and slowed down the pace of the sessions. They also felt less confident, and struggled to find words to express themselves. Both groups reported a *Connection*

with Latino clients which was attributed to sharing an ethnic background. *Translation* also emerged as a theme for the Heritage Speakers. Translating thoughts from English to Spanish affected attentiveness and pace in the sessions with the result of the session seeming less fluid and natural. The authors acknowledged that differences between the two groups may also be affected by the considerably longer periods of clinical experience in the Native Spanish Speaker group.

This investigation is methodologically sound with a clear account of analysis and the process used to establish the trustworthiness of findings (negative case analysis and triangulation). Although there is no explicit exploration of the relationship between researchers and interviewers, there is consideration of the assumptions and values of the principal investigators. There was heterogeneity in terms of the experiences being explored in this study, i.e. working with Latino or Anglo-American clients in Spanish, or English, or both. This means that although not acknowledged, there were two group of therapists and, in effect, two groups of clients, with different languages being used in sessions. As a result of this heterogeneity in the circumstances of the therapy sessions, these findings may benefit from further investigation into the specifics of each sub-group.

Systematic inquiry from the UK

Costa (2010) interviewed therapists who were working in a language that they shared with their clients, but was a non-native language for both of them. Data collection involved a questionnaire and a discussion with six multilingual therapists. Five themes were identified in this research: the importance of therapist bilingualism for positive outcomes in therapy, significance and meaning beyond words, learning the language and political identity, accessing emotions in a non-native language and emotional expression. The study has some methodological flaws. No method of analysis was identified. Moreover, in terms of the sample, five of the participants were employees of the author although how this may influence data collection or analysis was not discussed. There was no reflective element, nor are any quality measures mentioned.

Recently a study has been published which aimed to explore whether there were significant differences between multilingual and monolingual therapists in their beliefs, attitudes and practices with multilingual clients (Costa & Dewaele, 2012). The authors used an on-line Likert scale survey. They carried out an exploratory factor analysis on the results, using a principal components analysis (PCA). Their principal finding was based on the identification of a dimension from the PCA in which the monolingual participants differed significantly (p=0.001) from their multilingual colleagues. The authors write that "the multilingual therapists tend to view their ability to share a language, or to have a facility for languages with a patient as positive with respect to their capacity for attunement with the client. They are also mindful of the potential for boundary breaches and collusion" (p. 28). They called this dimension called *Attunement versus Collusion*. There were three other dimensions in which there were no significant difference between the monolingual therapists and their multilingual colleagues. These were *Shared understanding versus Acting on assumptions* (p= 0.68), *Freedom of expression versus Difficulty of challenging* (p= 0.12) and *Distancing effect of L2 versus Advantage of a shared language* (p= 0.76).

The authors then used findings from the PCA as a basis for semi-structured interviews with two multilingual therapists and one monolingual therapist. They suggested that the qualitative component proves further support for the dimension of *Attunement versus Collusion.* Through the semi-structured interviews they also suggested that there were differences between the multilingual therapists and the monolingual therapist in terms of one of the non-significant dimensions that were identified, *Shared understanding versus Acting on assumptions.* This referred to the conclusion that shared assumptions through a shared language may not always be beneficial for therapy.

Costa & Dewaele (2012) offered an additional finding at the end of their paper. The multilingual therapists considered English to be their *professional language*. Working in another language seemed to affect their access to vocabulary and fluency in this language, which the authors suggest may level power imbalances. The qualitative component of this study has some weaknesses. It seems that citations

from the interview were selected based on the support they provided for the dimensions for the PCA. Qualitative analysis is not discussed. It is therefore unclear if the qualitative data presented was the result of rigorous analysis. No quality measures were discussed. The discussion of quality measures would be particularly important given that it is a comparative qualitative investigation with small samples sizes for either group.

1.4.2.2 Practising as a multilingual therapist in a non-native language, which is the client's first language

Clinical papers and anecdotal evidence

A small quantity of literature focuses on therapy in the therapist's non-native language, when it is the client's first. Kitron (1992) had practised in French, English, and Dutch as well as his first language, Hebrew. He discussed the implications for transference and countertransference when working as a therapist in his or her non-native language, which is the client's first language. He wrote that in this situation a client in therapy can feel an advantage due to having greater proficiency in the language, with power being re-distributed between client and therapist. He went on to speculate (from a psychoanalytic perspective) that the client may find it difficult to accept weaknesses, such as not fully mastering the language, in the therapist . He also discussed what the therapist's experience of the therapy may be, including feelings of dependence, insecurity, inferiority and separation. His experience of three cases was then presented. In one, he gave an example of not fully understanding the vocabulary used by a client and having to ask, which he found embarrassing. As therapy progressed the client began to use less verbose language resulting in Kitron feeling more in control and at ease. In addition, in the context of transference-countertransference, he described how practising in a non-native language made him feel a lack of security, an urge to prove himself, to question his mastery of the language and feel controlled in terms of making therapeutic interventions. It is not easy to disentangle whether these feelings and experiences are attributable to dynamics in the session or the experience of delivering therapy in a language that is non-native for the therapist, but the first language of the client. What can be drawn from Kitron's paper is that language can alter power dynamics, therapist experience and therapeutic issues.

In a similar paper, Lijtmaer (1999) explored therapists practising in a non-native language and the impact on transference and countertransference in therapy. She presented reflections on her own clinical experiences, clinical vignettes from personal communication and examples in the literature. She suggested that therapists practising in a non-native language have to have an awareness of how comfortable they feel with their own identity as this may be challenged in interaction with the client. Furthermore, therapists may experience feelings of guilt at not being as controlled as they should be, or not mastering the language. They may also experience feelings of aggression toward the client for having to work harder to communicate, or humiliation if they are requested to repeat something. Lijtmaer went on to speculate that therapists may feel mortified if an accent impacts on the therapeutic experience of the client, may be more cautious with interpretations, and may neglect the client's feelings due to focusing more on language. Connolly (2002), who has English as a first language and Italian as a non-native language, discussed a case of analysis which took place Italian. Unfortunately, Connolly did not reflect on her experiences of working in a non-native language, and only discussed countertransference in terms of the client's presenting difficulties.

Jiménez (2004) provided an account of providing psychoanalytic treatment in German as a non-native language. The majority of his experiences as a therapist are located within a discussion of the client's fantasies and conflicts. However, he felt that he was particularly aware of how the German language was used providing fresh therapeutic insights. Karamat-Ali (2004) offered some reflections on the experience of practising as a bilingual systemic therapist, using a language that is not her first, in the UK. She felt, initially, that asking clients for clarification, or explanations of a word, felt awkward and caused concern in terms of developing a therapeutic relationship. Although asking about the meaning of words can slow a session, it also reportedly helped develop relationships with families and children.

Systematic inquiry

Morris & Lee (2004) carried out an exploratory investigation into the experience of giving therapy as a non-native English-speaking trainee of systemic therapy in the USA. The trainees were from Taiwan, Lithuania and Iran. The analysis generated

three themes. *Opportunity/benefit vs. barrier* referred to the idea that practising in a non-native language could facilitate the therapist to seek extra clarification and ensure their understanding. By contrast, at times, understanding the culture of the host country was difficult. *Time and learning* reflected the persistence and hard work that trainees felt they needed to understand North American culture and language and how time consuming this can be. The final theme of *Suggestions vs. expectations* comes from participants' desire to have more direct correction of their verbal and non-verbal performance in sessions.

The study has some flaws. The authors did not provide the reader with the interview schedule, but did provide example questions from the interviews with the trainees, one of which was ''How do you think that issues of language and culture will come up for you in your practicum training?'' There is an underlying assumption that predictions will accurately reflect future events. Furthermore, there is very little transparency around the analysis of the data from the interviews, or mention of researcher reflexivity. Moreover, the findings may of limited applicability to therapists working in a non-native language in the UK, given that it was a USA-based study.

1.5 Summary of the literature and research questions

Having reviewed what is known about the prevalence and language profiles of regulated therapists in the UK who are multilingual, it seems clear that there is an emerging interest in this sub-group of therapists. To the best of my knowledge, there are no data available about which languages are being used in therapy in the UK. Moreover, there appears to be a lack of data detailing whether therapists are practising in the languages in which they trained. In short, little is known about their professional activity in relation to their linguistic characteristics. As such, the first research questions of the current study is follows.

1. What are the demographic and linguistic characteristics and professional activities of a sample of multilingual therapists practising in the United Kingdom?

A review of the literature has shown that the experiences of multilingual therapist is largely focused on Spanish-English bilinguals reflecting large Latino populations in the USA. Although there is other research focusing on multilingual therapists, much of it is anecdotal. The anecdotal literature of therapists experience of working in a non-native language this is largely psychoanalytic, and therapists' experiences are described with client material. This means that is difficult to extrapolate findings. There is also little systematic inquiry which explores the experience of therapists working in a non-native language. As such the remaining research questions of the current study are as follows.

2. What are the main experiential features of practising as a therapist in English as a non-native language?

3. How do therapists practising in English as a non-native language make sense of these experiences?

4. What strategies are employed to overcome any issues faced?

5. For those participants who had trained in English, how do these experiences, and the associated sense making, compare to their experiences of practising in their first language?

1.6 Methodological considerations

The above research questions could be answered using various methods of data collection and analyses, located within different epistemologies. I will now discuss some methodological considerations.

1.6.1.My epistemological stance as a researcher

It is important to locate research within an epistemology to ensure that the methodology can be justified in relation to a specific theory of knowledge. The way I view the world, the knowledge in it and "truth" , has been influenced by the clinical work I have carried out as an applied psychologist. I have often heard stories from clients and together we have created a formulation of their life stories, linking, for

example, their early experiences, relationship patterns, thoughts, feelings, behaviours, strengths, life events and presenting difficulties. For me these formulations do not represent an answer or a discovery that will help unlock the "truth" of what has happened in the person's life. Instead, it is a form of shared understanding that we have created in that moment. It is imperfect and flawed and is just one perception, version or representation of many possibilities. However, it is what we decide to work with. It is a tentative snapshot of a reality that we have created. I am aware of, and accept, the assumption that it is a reality, and always try to be mindful that it is not an absolute truth.

This is largely how I view knowledge and I consider my epistemological stance as a researcher to draw from an interpretative / contextual constructionist epistemology (Madill, Jordan & Shirley, 2000). This epistemology rejects the notion of a single reality that exists independent of the observer. Instead, knowledge is viewed as a product of interaction between parties and as such it is co-constructed. Findings are embedded within and deeply influenced by context and the individuals creating the meaning. This means that objectivity is not given priority as it is not seen as possible and instead, completeness is an important aim. A single reality is not sought, but one that is rich, multiple and complete. Based on my perception of knowledge and "truth", I consider all individuals, including researchers, to be subjective beings who heavily influence any knowledge they produce and as this is inevitable, then it must be acknowledged. Consequently, I feel that as a researcher, it is important to be aware of my values, preconceptions, personal beliefs and characteristics and how these may influence results, and communicate this to the reader. As such, I will attempt to be open and transparent, enabling the reader to evaluate any findings within the context in which they were produced.

1.6.2 Qualitative and quantitative components of the study

To be able to answer the research questions of this project, I decided to use both qualitative and qualitative components. Ponterotto & Grieger (1999) state that using both quantitative and qualitative approaches can be complementary in research; they do not necessarily need to be considered as mutually exclusive and being able to incorporate both into research is valuable, advantageous and enriching.

I decided to use both quantitative and qualitative approaches based on the different kinds of research questions I was interested in. Research question one referred to the demographic, linguistic and professional characteristics of multilingual therapists. I considered these to be "facts" which would be most effectively explored via collecting quantitative data, largely frequencies. I see these "facts" in a similar way to the way I see a formulation. They are influenced by the questions I ask, the way the respondent perceives the question as well as wider influences, for example, whether a spoken form of communication is considered to be a language or a dialect. However, I knowingly hold an assumption that these "facts" represent a kind of reality, although it is not a reality that is independent of me as the producer and observer of the 'facts'.

Elliott, Fischer & Rennie (1999, p. 216) offer as the aim of qualitative research, "to understand and represent the experiences and actions of people as they encounter, engage, and live through situations". As such, a qualitative approach was most suited to research questions two to five. Having examined and identified the way in which I make sense of the world myself, I sought a method compatible with this. I examined several approaches, outlined below, and finally selected IPA. IPA was selected for the analysis method in this part of the study because the focus of interest was on how participants experienced practising in English as a non-native language, and how they made sense of these experiences. However, numerous forms of analysis that were considered for this study will now be briefly discussed.

Grounded theory

Grounded theorists (Glaser & Strauss, 1967) aim to ground their findings in the data. They adopt an inductivist approach to inquiry, i.e., theory emerges from data, rather than data being collected to test a specific hypothesis. It is particularly appropriate in areas that are under-theorised as it aims to achieve a final framework providing an explanatory model of a phenomenon. As such, the final result is usually a model of the phenomenon in question.

Discourse analysis

Discourse analysis is based on the premise that when people talk they construct their social and personal world. Therefore language is central in this form of analysis. Individuals have a 'stake' in what they talk about and create different versions depending on context. Discourse analysis can take a 'bottom-up approach' (e.g. Potter & Wetherell,1987) focusing on how people interact and position themselves through language. Alternatively, a 'top-down' approach can be used looking at how discourses position people and with a focus on power and resistance(e.g. Foucauldian analysis, see Parker, 1992).

Interpretative Phenomenological Analysis (IPA)

Smith, Flowers & Larkin (2009, p. 40) wrote that Interpretative Phenomenological Analysis is a form of qualitative analysis through which "we commit ourselves to exploring, describing, interpreting and situating the means by which our participants make sense of their experiences". IPA draws from two major theoretical bodies – phenomenology to explore experience and hermeneutics to explore interpretation and sense-making of these experiences. Smith, Flowers & Larkin (2009) provide an account of some of the principal contributors to the theoretical underpinning of IPA and an overview will be provided here.

Phenomenology is a philosophical endeavour which explores human experience and what it is like to be a human. It involves moving from focusing on the objects we experience to focusing on the experience itself, which is often taken for granted. This means 'bracketing off' an experience and stopping to reflect on it. Heidegger (1962/1927, cited by Smith, Flowers & Larkin, 2009) emphasised that experience is always embedded in a context and is therefore relational and shared in nature. He argued that to move from an object to the experience of that object as a focus of perception is not possible due to this relatedness nature of our experience –we are too inextricably linked to them, and the experience, to be able to separate ourselves from the things we experience. Heidegger also claimed that experience was inseparable from interpretation. Merleau-Ponty (1962, cited by Smith, Flowers & Larkin, 2009) brings embodiment as central to human experiences stating that as an individual's experience always starts from his or her embodied perspective then all

human interactions start from a point of difference and as such fully sharing an experience with another is not possible.

Hermeneutics is the theory of interpretation, and includes making sense of events and attributing meaning. When we are interpreting a text or transcript, the distinction can be made between understanding the writer or speaker and understanding the text. IPA takes that stance that an interpreter's account is not more 'accurate' but may be able to offer more meaningful insights through systematic analysis, using larger data sets and drawing from psychological theory. The role of the interpreter, and the inherent subjectivity, is central and its importance cannot be minimised or controlled. To every experience that a person tries to interpret or give meaning to, they bring a lifetime of experiences, assumptions and preconceptions. Although these 'fore-structures' obviously precede any experience of new things, it may be that their impact or relation to the experiences, and interpretation, can only be explored and recognised afterwards.

The 'double hermeneutic' is a central concept in IPA and refers to the notion of being two steps away from the 'actual experience' of an individual. As researchers, we interpret the participant's interpretation of an event and it is here where the researcher has to be aware of what he or she brings to the interpretation and findings, through open reflection.

In summary, IPA is phenomenological in "attempting to get as close as possible to the personal experience of the participant, but recognizes that this inevitably becomes an interpretative endeavour for both participant and researcher" (Smith, Flowers & Larkin, 2009 p.37). Although discussed here separately it is important to note that phenomenology and hermeneutics are intricately linked and it is not possible for one to be present without the other.

1.6.3 Overview of the study design

Taking into account my epistemological stance and the nature of the research questions, this study was designed using quantitative and qualitative components.

It was divided into two parts. The first largely quantitative and the second qualitative. The first part was a web-based survey, which was completed by multilingual therapists across the UK. The aim of the web-based survey was twofold, firstly to collect data from as many multilingual therapists as possible to be able to answer research question one. The second aim was to provide context to, and recruit for, the second and principal part of this study. The second part of the study consisted of semi-structured interviews with six multilingual therapists who were working in English as a non-native language in the UK. The use of semi-structured interviews as a data collection method was to gather rich qualitative data which would help answer the remaining research questions.

Chapter 2: Web-based survey

In this chapter I present the method and findings from a web-based survey completed by multilingual therapists across the UK.

2.1 Rationale

There is a growing interest in gathering data regarding multilingual therapists practising in the UK. We know relatively little about the languages they practise in, the language they trained in or the proficiency of those languages. The aim of the web-based survey was to gather demographic and professional data to contribute to the emerging knowledge base. Context and recruitment for part two of the study were also aims of the web-based survey.

2.2 Methodology and data generation

A web-based survey was designed and distributed to be completed by therapists who consider themselves to be proficient in more than one language. The survey largely generated quantitative data, although a small amount of qualitative data was also collected .

2.3 Materials and development of the survey

The survey was largely based on The Language and Proficiency Questionnaire (LEAP-Q) (Marian, Blumenfeld & Kaushanskaya, 2007), which the authors describe as a tool for assessing the language profiles of multilingual adults for research purposes. It has good criterion-based validity, established through Pearson's R correlations analyses between self-report measures and measures of behavioural proficiency across different language modalities (including reading fluency, productive vocabulary, oral comprehension and sound awareness). Of three self-report measures (speaking, comprehension and reading) self-reported speaking proficiency was found to be a more accurate predictor of second language proficiency with correlations ranging from -.34 for grammaticality judgment reaction

time to .74 for passage comprehension. All correlation coefficients were significant to at least .05.

The LEAP-Q was chosen as it is the only self assessment tool identified that specifically addressed the complexities in gathering data about the acquisition of more than one language, such as proficiency, experience across different domains and a wide range of skills for research purposes. By using this pre-existing self-assessment tool, good criterion-based validity allowed for self-reported speaking proficiency to predict overall second-language proficiency. However, whilst the LEAP-Q facilitated the collection of data about languages spoken, it was not sufficient given that the aim was also to gather information about clinical training, background and work; as well as demographics.

In addition to the LEAP-Q, additional questions were added to the survey. It was anticipated that these additions would make the overall survey more and more tailored than a pre-existing questionnaire. These are written in blue in the version of the full survey that can be found in Appendix II. These additions were made with the intention of collecting data about demographics, place of birth and date arrival in the UK (where applicable). Questions were also added to gather data about training and current clinical work as a therapist. The decision was also taken to gather some qualitative data on the kinds of challenges that multilingual therapists may face. As such, free text boxes were included to allow for three challenges, and corresponding strategies, to be entered. The survey was presented and distributed using Bristol Online Surveys, which allowed nationwide dissemination.

2.4 Participants and recruitment

The web-based distribution of the survey facilitated access to a potentially large pool of multilingual therapists working across the UK; the aim was to include as many participants as possible. Recruitment was through snowballing, and was carried out electronically using email, the internet and via relevant publications. Participants were recruited through the following avenues:

1. Emails were sent to all contacts (N=427) on the database of the Leeds Doctorate in Clinical Psychology training course.
2. Emails were sent to all training courses (N=29) across the country to disseminate to local practitioners and trainees.
3. Emails were sent to three specialist inter-cultural therapy and counselling services: *Solace* in Leeds, *Mothertongue* in Reading and *Nafsiyat Intercultural Therapy Centre* in North London.
4. A small advertisement was placed on the website of The UK Council for Psychotherapy and in The Psychologist magazine, published by The British Psychological Society (see Appendix III).
5. A post was placed on a discussion forum for qualified, training and aspiring clinical psychologists in the UK (www.clinpsy.org.uk).

Emails contained information regarding the project and a link to the Bristol Online Survey. The aim was to make contact with as many multilingual therapists as possible to ensure the data gathered were as meaningful as possible. It was also anticipated that this would facilitate recruitment for part two of the study, as participants could be selected from a diverse set of individuals willing to take part. This would mean that they could be selected based on commonalities between them, thus supporting homogeneity of the sample for the interviews and qualitative analysis. The inclusion criteria for part one of the study can be seen in Table 1.

Table 1: Inclusion and exclusion criteria for the web-based survey

Inclusion criteria	Exclusion criterion
1. Multilingual 2. Accredited therapist or in training for accredited qualification in the UK 3. Currently engaged in clinical work with clients in the UK	1. Monolingual

2.5 Ethical issues

Ethical approval was given by the University of Leeds Faculty Research Ethics Committee on 18th May 2011 with the reference HSLTLM/10/026 (see Appendix IV).

The first page of the survey consisted of the Participant Information Sheet containing relevant information about the survey and consent was addressed on the second page (Appendix V). Participants were requested to consent to participate by clicking 'continue' and completing the survey.

All data gathered via the survey were anonymous and encryption software was in place to ensure that data could not be intercepted by a third party. At the end of the survey participants were asked if they would like to participate in part two of the project with a brief explanation of what would be involved and they were invited to leave their contact details. Participants were able to opt out of the survey at any point simply by closing the browser.

2.6 Treatment and analysis of quantitative survey data

The quantitative data generated by the survey were exported from the Bristol Online Survey website to an Excel spreadsheet, 'cleaned' and then exported to SPSS for analysis using descriptive statistics and frequencies. Descriptive statistics were used as the aim was to explore and describe the data, and not to infer any relationships that could be generalized to a wider population.

2.7 Treatment and analysis of qualitative survey data

Qualitative data were generated by the section of the survey which read: *Please list three challenges you have faced when delivering therapy in a language that is an acquired second language for you, and strategies you have used to overcome them.* These data were exported to Excel.

A thematic analysis (Braun & Clarke, 2006) was carried out. Using definitions set out by Braun & Clarke, the analysis was theoretical (as opposed to inductive) and produced semantic themes (rather than latent). This means that the analysis was analyst-driven, in response to a specific research question, with a focus on a particular aspect of the data, in this case different types of *challenges* and *strategies* used. Themes were identified at the semantic level, i.e., there was a focus on explicit or surface meanings. The stages of the thematic analysis (based on Braun & Clarke) can be seen in Table 2 overleaf.

Table 2: Stages of the thematic analysis of qualitative survey data

	Stage	Description
1	Familiarised self with *challenges*	The *challenges* were read and then read again. Any initial thoughts or idea were noted.
2	Generated initial codes	Codes were then generated and noted.
3	Searched for 'clusters' in *challenges*	The list of codes was reviewed and the *challenges* were grouped together into 'clusters', which were given a name. This cluster and its name were then considered to be a theme.
4	Reviewed themes	Themes were checked in relation to the codes which were subsumed by them. This was to ensure that codes belonged to the theme. The 'clusters' were examined to ensure that the themes reflected the *challenges* specified by participants across the whole data set. It is here that the master themes and sub-themes were identified.
5	Defined themes	A description of each master theme and sub-theme was written.
6	Explored relationship between themes of *challenges*	The themes and their inter-relationships were then represented diagrammatically.
7	Reunited *challenges* with *strategies*	Each individual *challenge* (unit of data) was then grouped under the relevant theme heading it subsumed and was paired with its original *strategy*, thus forming groups of *strategies.*
8	Analysis of the *strategies*	Steps 1 to 3 were repeated for the newly re-grouped *strategies.*
9	Produced table for report	The themes that were identified from the *strategies* were named and listed by the *challenge* that they related to and inserted in a table.

The decision was taken to carry out the analysis on the *challenges* first followed by the *strategies*. This was to maximize the applicability of the findings: it was

anticipated that from examining the final table of themes, therapists would be able to identify a theme that may represent a challenge they had faced, and find a list of possible strategies to help them overcome it.

2.8 Results of the quantitative survey data

In total, the survey was live online for 19 weeks and was completed by 103 participants. Two response sets were removed; one participant had only responded to the age question, whilst another responded in terms of their use of British Sign Language. The second participant was removed because of the focus of the research question on languages that are *spoken*. Therefore the final sample size for the web-based survey was 101.[1]

Demographic and language data

Table 3 shows demographic data for those who completed the web-based survey, along with demographic data from Costa & Dewaele (2012), The British Association for Counselling and Psychotherapy (BACP) and The Health Professions Council (HPC). The demographic data from Costa & Dewaele (2012) is included for illustration and it should be noted that their survey sample included monolingual therapists. Although the BACP and the HPC are not the only two bodies that regulate therapists, their data are useful in providing approximations for comparison between survey participants and the wider profession. As can be seen, percentages of the gender of survey participants are similar to data from other sources, with females accounting for around 80% of all groups. The data for age show a similar pattern, with the largest groups being 30-39 and 40-49 years, respectively. Sample age data may be slightly skewed towards the younger age groups for survey participants as recruitment was largely carried out though Clinical Psychology training courses, resulting in a substantial percentage of survey participants being trainee therapists, who, it may be hypothesised, are slightly younger.

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[1] Where percentages are not given below, it is to be assumed that to two decimals points, the percentage is the same as the frequency, given that the final sample size was so close to 100.

Table 3: Demographic data for survey participants, Costa & Dewaele (2012), all BACP members and HPC registered clinical and counselling psychologists

	Web-based survey		Costa & Dewaele (2012)		All BACP members*		HPC registered clinical or counselling psychologists&	
Frequency (%)	101	(100)	101	(100)	36 505	(100)	11259	(100)
GENDER								
Female	87	(86)	84	(83)	30656	(84)	8680	(77)
Male	13	(13)	17	(17)	5849	(16)	2567	(23)
Not known	1	(1)	0	(0)	0	(0)	12	(0)
AGE								
Up to 29	17	(17)	-		958	(3)	-	
30-39	49	(49)	-		4240	(12)	-	
40-49	21	(21)	-		10295	(28)	-	
50-59	13	(13)	-		5530	(15)	-	
60-69	1	(1)	-		622	(2)	-	
Unknown	0	(0)	-		3881	(11)	-	

*Data from December 2011 &Data from November 2011

Table 4 shows the frequency of countries of origin in the sample. In total, 30 different countries of origin were identified. Forty-three of those who completed the survey gave the United Kingdom as their country of origin; 8% Germany; 6% Greece; and 4% Finland, Poland and Spain.

In total 39 spoken languages were identified by respondents. These were: Albanian, Arabic, Armenian, Bengali, Burmese, Catalan-Valencian-Balear, Chinese / Cantonese, Dutch, English, Finnish, French, Galician, German, Greek, Guajarati, Hebrew, Hindi, Irish, Italian, Lithuanian, Llanito, Luxembourgish, Malay, Marwari, Norwegian, Panjabi, Polish, Portuguese, Russian, Serbian, Serbo-Croatian, Spanish, Swedish, Tamil, Turkish, Urdu and Welsh. In the survey, there was a free text option box; two languages that were provided by participants were Scottish and Gaelic. It is

therefore unclear whether Scottish refers to Scots Language or Scottish Gaelic, and similarly it is unclear whether Gaelic refers to Irish Gaelic or Scottish Gaelic[2].

Table 4: Countries of origin of survey respondents

COUNTRY OF ORIGIN	Frequency (per country of origin)
United Kingdom	43
Germany	8
Greece	6
Finland, Poland, Spain	4
India, Russia	3
Netherlands, Pakistan, Portugal	2
Algeria, Argentina, Austria, Canada, China, Cote d'Ivoire, Yugoslavia[3], France, Gibraltar, Hong Kong, Ireland[4], Israel, Italy, Lithuania, Malaysia, Mexico, North Cyprus, Sudan, Sweden, Unknown.	1

English was the most frequent for first and second language. The proficiency of English (for those who did not have it as a first language) based on measures of central tendency (mean, mode and median) of self-reported speaking proficiency was 9 (out of ten) indicating *excellent* levels of proficiency (Range = 7-10, SD = 0.81).

[2] For further reference or information on the categorisation of languages, please see *Ethnologue: languages of the world* (Lewis, 2009).

[3] Although it is recognised that Yugoslavia no longer exists, the country of origin was provided by the participant as "ex-Yugoslavian".

[4] The terms "Republic of Ireland" and "Northern Ireland" were not used in the survey, as such it is unclear whether this refers to the Republic of Ireland or Northern Ireland. The limitations of the survey are discussed below.

After English, the languages with the highest frequency were French, Spanish, German, Welsh and Italian. Overall, 54 participants claimed proficiency in three languages, 24 individuals in four languages and 11 people five languages.

The *most dominant language* for each respondent was cross tabulated with the *language first acquired*. For 94 of the 101 respondents, the most dominant language was the same as the one that was first acquired. There were six individuals who considered English to be their most dominant language although their first languages were Spanish, Finnish, Guajarati, Punjabi, Urdu and Welsh, respectively. One individual felt Portuguese was their most dominant language although English was acquired first.

Education, training and professional data

Overall, 65% of the sample identified a Clinical Doctorate or PhD as their highest level of educational training, whilst 19% identified their highest level of training as a Masters. The large majority of participants had done their training in the UK (83%) and in English (85%) and the majority of the sample (78%) were either qualified or trainee clinical psychologists.

Comparison of language and professional data

The most frequent professional groups represented (accounting for 86% of the full sample) were cross tabulated with first language. Examination of the data in Table 5 showed that 52 of the 87 respondents (60%) in the top five professional groups did not have English as a first language and that nineteen languages were spoken.

Table 5: Top five professional groups and first language

	Clinical psychologist	Trainee Clinical psychologist	Counselling psychologist	Trainee Counselling psychologist	Counsellor	Total
English	17	17	1			35
Welsh	7	1	1			9
German	5	3				8
Greek	1	5				6
Polish	1	3				4
Chinese / Cantonese		3				3
Finnish	1			1	1	3
Portuguese	2	1				3
Spanish	2				1	3
Arabic			1		1	2
Dutch	1			1		2
French	1			1		2
Albanian		1				1
Catalan-Valencian-Balear	1					1
Hindi	1					1
Lithuanian		1				1
Russian		1				1
Swedish	1					1
Turkish		1				1
Total	41	37	3	3	3	87

Table 6: Cross tabulation of *Languages used to deliver therapy*

	Have you delivered therapy in this language?				
	FIRST LANGUAGE	SECOND LANGUAGE	THIRD LANGUAGE	FOURTH LANGUAGE	FIFTH LANGUAGE
Yes	79	67	17	3	-
No	19	29	27	16	10
Unknown / NA	3	5	57	82	91
	101	101	101	101	101

Table 6 shows the extent to which the full survey sample had delivered therapy in their different languages, with 67% of the sample having delivered therapy in a second language, 17% in a third language and 3% in a fourth language.

English as a non-first language data

By cross-tabulating two further variables (whether therapy training had been delivered in English or not and participants' first language) it can be seen in Table 7 that of the 60 participants who did not have English as a first language, 45 received initial therapy training in English, whilst the remaining 15 received training in another language. However, as can be seen in Table 8 all respondents had delivered therapy in English.

Table 7 : Cross tabulation of *Therapy training in English* and *First language*

		THERAPY TRAINING		
		ENGLISH	OTHER LANGUAGE	
FIRST LANGUAGE	ENGLISH	40	1	41
	OTHER LANGUAGE	45	15	60
		85	16	101

Table 8: Cross tabulation of *Delivered therapy in English* and *First language*

		DELIVERED THERAPY IN ENGLISH?			
		YES	NO	UNKNOWN	
FIRST LANGUAGE	ENGLISH	40	0	1	41
	OTHER LANGUAGE	56	0	4	60
		96	0	5	101

2.9 Results of the qualitative survey data

Overall, 118 individual challenges were named by respondents. Five master themes were identified and, in total, eight sub-themes, which are represented in Figure 1.

Challenges of expression for therapist

This master theme related to the challenges of expressing oneself in therapy. The five sub-themes were *Not knowing or remembering vocabulary*, *Not knowing therapy terminology*, *Not being understood due to accent*, *Difficulty with written language* and *Equivalent words not existing* across languages.

Challenges of comprehension for therapist

This master theme referred to the difficulties encountered in understanding. The three sub-themes were *Not understanding client accent or dialect*, *Not understanding slang or colloquialism* and *Not understanding general vocabulary used by client*.

Slower therapy sessions

This third master theme was identified as respondents felt that the pace of their sessions slowed down. This was seen as a result of the *Challenges of expression for therapist* and the *Challenges of comprehension for therapist*, which were felt to be more time consuming. Given that these two master themes contributed to the theme of *Slower therapy sessions*, arrows represent this in the respective colours in the diagram.

Lack of materials and resources

This fourth master theme referred to not having appropriate resources or materials in different languages.

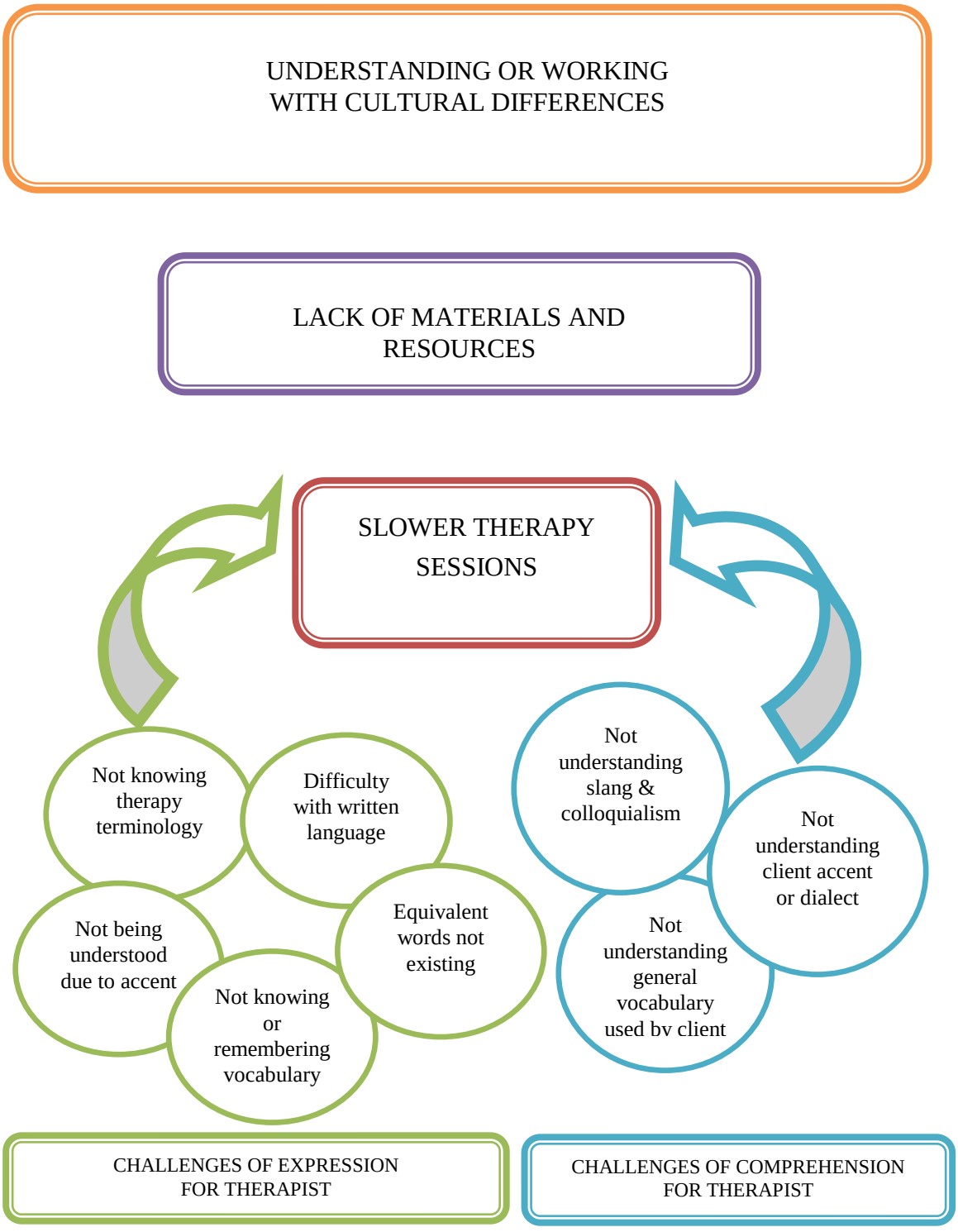
Understanding or working with cultural differences

This final master theme referred to the challenges of working across cultures, or with clients from cultural backgrounds different to their own. The latter two master themes are represented in the diagram as overarching and encapsulating the other three master themes. This is because the encapsulated three master themes refer specifically to issues within the therapy sessions, whilst *Lack of materials and resources* and *Understanding or working with cultural differences* referred to wider issues that respondents felt were challenges when practising in a non-native language.

Strategies to deal with challenges

Strategies to deal with *Challenges of expression for therapist* focused on learning new language and vocabulary from reading or colleagues, being open about difficulties and asking for feedback and paraphrasing. To deal with the *Challenges of comprehension for therapist*, respondents asked for clarification, were open about difficulties with comprehension, used context and non-verbal communication to draw meanings. *Slower therapy sessions* were dealt with by allowing for longer therapy sessions, or contracting for more. Respondents dealt with the *Lack of materials and resources* in different languages by creating their own resources and translating them where appropriate and possible. Finally, the strategies to work with challenge of *Understanding or working with cultural differences* included learning and asking about culture through supervision, from the client and independent reading. In Appendix VI the themes are presented with example citations and with the strategies identified by respondents to deal with the challenges.

Figure 1: Master and sub-themes of challenges faced by multilingual therapists



Key

- Master themes are represented rectangles with a double outline.
- Sub-themes are represented in circles with a single outline.
- Sub-themes are presented in the same colour as the master theme that subsumes them.

2.10 A critical review of the survey and findings

Whilst the responses, and therefore the results, presented here are assumed to represent a reality, it is acknowledged that this reality is not detached from the observer, nor does it represent an absolute truth. Moreover, subjectivity should be acknowledged in the production of the knowledge.

The question added to the LEAP-Q meant that the survey had some limitations. Firstly, the confounding of *nationality* and *country* in question four and the options in the dropdown box means that this question was possibly unclear for respondents. A lack of specificity in some of the options provided in the survey, such as "Ireland", meant that it is not possible to establish the specifics of responses, such as whether respondents were referring to Northern Ireland or the Republic of Ireland.

The final section of the survey asked respondents to list the challenges (and strategies used) in practising as a multilingual therapist. Experiencing challenges as a multilingual therapist is in line with experiences discussed in the literature in Chapter One. By asking about them explicitly it may introduce an assumption that challenges are experienced for survey respondents and may prioritise them over any other type of experience. An alternative may have been to ask "Do you think working in a different language impacts on your work as a therapist? If so, how?". This may have allowed a move away from my assumptions as a researcher. As Fine (1994) highlights, it is the researcher who "defines the problem, the nature of the research, and, to some extent, the quality of the interaction" (p. 73). It is therefore important that the findings of the survey be considered in light of the these issues.

2.11 Web-based survey results: concluding comments

This web-based survey was live on line for 19 weeks and during this time was completed by 101 people who were multilingual and trainee or qualified therapists. Data from, Costa & Dewaele (2012), the BACP and the HPC suggest that the sample is representative of the wider therapist professions in terms of demographic data.

The 30 countries of origin and 39 languages identified show that there is a wide range of countries of origin and linguistic profiles within this sample and therefore

the profession. Costa & Dewaele (2012) reported 20 nationalities in their survey and did not provide an overall figure for the number of languages in their sample, meaning comparison was not possible. The findings from the current survey suggest that English was the language with the highest frequency as both the first and second language across the sample. For the majority of respondents, their first acquired language coincided with their most dominant language. The majority of those who completed the survey were trainee or qualified clinical psychologists, which is not surprising given that recruitment was largely carried out through doctoral training programmes in Clinical Psychology.

There are unique contributions of this web-based survey. Firstly, the data regarding *actual* experience of delivering therapy in different languages suggests that 19% had no experience of delivering therapy in their first language. Moreover, 67% had experience of delving therapy in a second language, 17% in a third and 3% in a fourth. Secondly, the majority of those who did not have English as a first language had received therapy training in English. Thirdly, the proficiency of English for those who did not have it as a first language was self-rated overall as *Excellent*.

The findings help provide context to exploring the issues and experiences of multilingual therapists in the UK. Working as a multilingual therapist is a contemporary and relevant issue to be investigating in the UK. However, the data and findings do not provide a rich account of what it is like to work as a multilingual therapist . To do this a change in method and analysis is required. I will now present the second part of the study and explore the experiences of a small sample of multilingual therapists who were recruited through the web-based survey.

Chapter 3: Interview Method

The aim of the second stage of the study was to develop an understanding of participants' experiences of working as therapists using English as a non-native language. This involved semi-structured interviews, analysed using Interpretative Phenomenological Analysis.

3.1 Participants and recruitment

The aim of this research project was to explore the experience of working in English as a non-native language for multilingual therapists in the UK. This means that it was an exploration of a specific phenomenon for a particular group of people in a particular context. As such, purposive sampling was appropriate.

The issue of homogeneity within this sample raises some interesting challenges. Smith, Flowers & Larkin (2009) distinguish between practical and interpretative issues with homogeneity and both are relevant in this project. Firstly, the practical issue of homogeneity had to be considered. There are few data, regarding the number of multilingual therapists practising in the local region or the UK in English as a non-native language. The practicalities of recruitment involved locating and contacting potential participants. Nationwide snowballing through the web-based survey meant that it was easier to reach a larger pool of potential participants for this part of the study, helping overcome the practicalities of locating and contacting multilingual therapists. Secondly, the interpretative issue of homogeneity had to be addressed. This refers to defining the characteristics upon which homogeneity will be based. This is a particularly complex issue given the challenge involved in the operationalisation of multilingualism. There are many factors to consider including: languages spoken and which overall language group, country of origin, cultural background, years spent in the UK, years spent practising in English, languages used in practice, where training took place and the language in which training took place. Demographic and linguistic information was gathered through the survey for all those who consented to being considered for semi-structured interviews. It was anticipated that this would allow participants to be selected based on having similar

characteristics. This would mean that homogeneity would be maximized, taking into account issues such as their stage of training.

For IPA research, Smith, Flowers & Larkin (2009) suggest that it is more important to focus on the number of interviews rather than number of participants per se. They recommend between four and ten interviews for professional doctorate research. Following these guidelines, the aim for part two of this research project was a sample size of between six and eight. It was anticipated that this would allow detailed examination of individuals' accounts whilst allowing for an exploration of similarities or differences between the accounts.

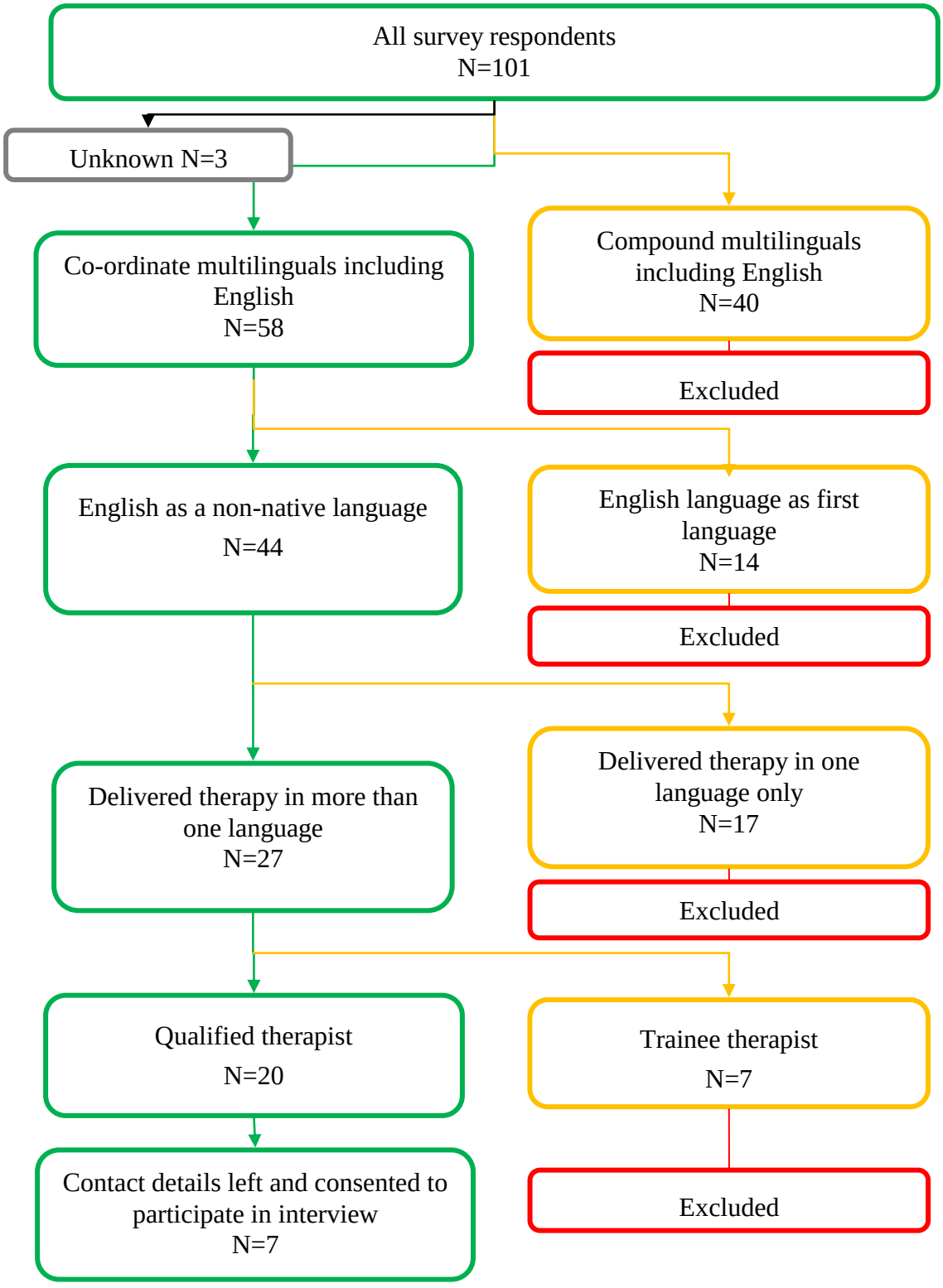
At the end of the web-based survey, all participants were asked if they would be willing to be interviewed to further discuss their experience as a multilingual therapist and were invited to leave their contact details. An email was sent to those who left their contact details and fulfilled the inclusion criteria (see Table 9). A Participant Information Sheet (Appendix VII) and Consent Form (Appendix IIX) were attached to the email. Potential participants were informed that if they wanted to participate they could reply to the email or they would be contacted again in two weeks time.

Table 9: Inclusion and exclusion criteria for semi-structured interviews

Inclusion criteria	Exclusion criteria
1. Co-ordinate multilingual 2. Accredited therapist or in training for accredited qualification in the UK 3. Currently engaged in clinical work with clients in the UK in English as a non-native language	1. Monolingual 2. English as a first language 3. Compound multilingual only

Participants who had practised in more than one language, including English, and were qualified were prioritised for selection for this part of the study. It was anticipated that would allow for comparison of experiences across languages, and that qualified therapists might have a wider range of experience to discuss. The breakdown of respondents is represented in Figure 2.

Figure 2 : Survey to interview recruitment flow diagram



The distinction between co-ordinate and compound was made with reference to Meisel's (2005) definition that simultaneous acquisition of languages occurs if an child begins to acquire two more languages before the age of four years of age. Due to the limited number of qualified therapists who responded to invitation to interview, no further eliminations were made. An email of thanks was sent to all those who left contact details but were not selected for the second part of the study. Interviews were arranged with via email or telephone at a time and place of convenience for participants.

In total, seven participants were recruited for semi-structured interviews. However, during one interview it became apparent that the participant had only practised in English, and not her first language, and the interview was excluded. The final sample for the qualitative analysis consisted of six female participants. Further demographics of the sample can be seen in Table 10.

3.2 Ethical issues

Whilst there were no major ethical issues, there were some ethical considerations in relation to therapist and client confidentiality. As with the web-based survey, ethical approval was given by the University of Leeds Faculty Research Ethics Committee on 18th May 2011 with the reference HSLTLM/10/026 (see Appendix IV).

3.2.1 Informed consent and withdrawal

Participants were sent by email a Participation Information Sheet before interviews that clearly stated the content and process of the project. Before the interview, participants were given the opportunity to ask any questions and have them answered. They were then asked to read and sign a Consent Form. Once the Consent Form was signed, all parties received a signed and dated copy, as well as a copy of the Participant Information Sheet.

Table 10: Demographics of sample

Demographic	Sample
Age range	30-39 (5)
	40-49 (1)
First language	Spanish (1)
	Catalan (1)
	German (2)
	Portuguese (1)
	Polish (1)
Years in UK	More than fifteen years (1)
	Ten to fifteen years (2)
	Five to nine years (3)
Trained in English	Yes (4)
	No (2)
Employment	Public sector (5)
	Private sector (1)
Profession	Clinical Psychologist (5)
	Counsellor (1)
Orientation	Psychodynamic (3)
	CBT (2)
	Systemic (1)

It was stated on the consent form that participants had the right to withdraw before or during the interview without giving any reason and without there being any negative consequences. Participants were informed on the Participation Information Sheet that it would not be possible to withdraw once the interview had been completed. At the end of each interview, participants were asked on tape if there was any content in the interview about which they felt uncomfortable. No concerns were raised by any of the participants in response to this.

3.2.2 Confidentiality

All data were anonymised through the removal of information such as names and places of work, and pseudonyms were chosen to use in interview transcripts and analysis. However, there remained a possibility that the combination of first language, therapeutic orientation and professional setting could mean that individuals were identifiable. For this reason, this information was not presented as

attributable to one specific pseudonym. Participants were informed of this at interview. There was potential for the interviews to contain conversations about work and therapy with clients. Participants were requested to respect the usual protocol in terms of client confidentiality and not use client names or identifiable information. All participants adhered to this guideline and the participants and I were confident that confidentiality had been preserved.

3.2.3 Data storage

A copy of the signed and dated consent form were kept with the project's main documents in a locked filing cabinet on University of Leeds premises. Audio data were stored on the M drive of the University of Leeds and removed from the recorder following this transfer. Recordings will be erased after the degree is completed. This decision was taken because of the potential for disclosure of confidential clinical material. Transcripts will be kept by the research support officers for the prescribed period of three years.

3.3 Producing data

It was decided to use semi-structured interviews, as they provide detailed, flexible, rich accounts of experience. Reid, Flowers & Larkin (2005) say that semi-structured interviews "are easily managed; allow rapport to be developed; allow participants to think, speak and be heard; and are well suited to in-depth and personal discussion" (p.22). Thus, there is a good fit between the research questions exploring individual experience and the flexibility of semi-structured interviews whilst allowing for a focus on the topic of interest.

3.3.1 Materials and pilot interviewing

As recommended by Smith, Flowers & Larkin (2009), an interview schedule was developed to guide the semi-structured interviews, which can be seen in Appendix X. The first two questions (and prompts) focused on how the participant came to be multilingual and the reasons they came to the UK, before going on to consider how the participants had come to be a therapist. The intention was to gather information to be able to provide context to the participants' accounts from the interview, as well as for the participant to be able to relax and feel engaged, allowing a relationship to

develop with the interviewer. The schedule then looked at experiences from the beginning of the participant's career, asking about a specific case to be able to gather detailed data on experience, and the meaning-making process. By subsequently asking about a current clinical case, it was anticipated that comparisons might be made between current and earlier clinical practice. The final two sections of the schedule dealt with emotional reactions. Questions were designed to elicit responses about participants experiences and accounts of particularly a strong emotional reaction and then a more everyday emotional reaction. The intention was to try and ensure that emotional experiences discussed did not just reflect extreme or unusual cases, but more common day experiences also. Once fully developed, the schedule consisted of ten questions along with prompts if needed. As expected this was not followed rigidly in interviews and was used to provide structure as and when required.

A pilot interview was carried out with a qualified clinical psychologist who was a compound bilingual with German and English (thus not meeting inclusion criteria for part two of the study). This helped me familiarise myself with the schedule and helped highlight potential improvements, such as refining questioning techniques.

3.3.2 Collecting data

All the interviews took place in a convenient location for the research participant, including participants' homes and places of work. Interviews were audio-recorded on a digital device. Immediately after each interview, I spoke about my thoughts, feelings and reflections into the recording device, resulting in two audio files per interview: the interview itself and my own 'reflective monologue'. The 'reflective monologue' had not been pre-planned but emerged as a useful way to immediately and easily capture my reactions to the participant and to the interview process, which could be used as "useful resources for the subsequent contextualization and development" of the analysis (Smith, Flower and Larkin, 2009, p. 73)

3.4 Process of analysis

All data collection had been completed by the time analysis began. The first stage of analysis involved listening to the audio file of the interview and noting any thoughts or reflections in a reflective journal. The interview was then transcribed. I transcribed the first interview to immerse myself in the data. Transcribers were used for the remaining interviews. Where transcribers were employed, they were required to sign a Confidentiality Statement (Appendix IX). I transcribed all the 'reflective monologues' myself. The full process of data analysis is detailed in Table 11 overleaf.

The first stages of analysis involved trying to become immersed in the audio and written data. When making initial notes I made an effort not to focus too heavily on what type of data were being noted (phenomenological, interpretative, descriptive or linguistic). Some notes were descriptive (*"language mistakes in meetings"),* whilst others were more interpretative focusing on what the experiences were *like* for that particular participant *("beginning to feel devalued because she's under scrutiny – felt attacked"*). There was also a focus on linguistic noting – thinking about which words and grammatical structures were used to speak about experiences (*"she places herself as the object : the language plays a game with me"*). Initial noting progressed to more conceptual issues, moving from the descriptive to relating to wider issues such as professional competence, self esteem or identity *("Desire to be seen as competent? And language mistakes make this difficult? What would happen to her if she wasn't seen as competent? Rejection? Doesn't fit with her identity?"*). During this stage, I also noted process issues that felt important, and incorporated notes from my reflective journal and the reflective monologues. This process was repeated for each transcript.

Table 11: Descriptive steps of IPA analysis

Step 1:	Carry out interview.
Step 2:	Record researcher reflective monologue directly afterwards (and transcribe).
Step 3:	Listen to audio recording of interview (without transcript) making any notes in reflective journal.
Step 4:	Transcribe interview.
Step 5:	Listen to audio recording of interview with electronic version of transcript making necessary amendments or corrections.
Step 6:	Listen to audio recording of interview with hard copy of transcript making any reflective notes in journal.
Step 7:	Read transcripts highlighting, passages of particular interest: underlining words or sentences and making brief notes on the transcript.
Step 8:	Read transcripts and make longer notes, thoughts, reflections and memos. Make relevant links to entries in the reflective journal and from the 'reflective monologue' transcript. Repeat stage seven and eight 6-7 times for each transcript.
Step 9:	Write a 'participant and interview overview' for each participant (no more than 2 sides of A4 paper)
Step 10:	Read transcripts and write a list of potential themes on a separate page.
Step 11:	Create table (for each participant) with four columns and insert participant initial, potential theme name and description or notes, supporting citation and line number.
Step 12:	Cut the table into individual strips of paper, so each strip had: participant initial, potential theme name (and description), supporting citation and line number.
Step 13:	For each participant individually, re-group all the pieces of paper together on the floor, moving them around and refining theme names and which citations belong to which group.
Step 14:	Produce a mind-map for each participant giving an overview of the themes and line numbers of supporting citations.
Step 15:	Begin group analysis: Take all the strips of paper from all participants. Mix them together and start to group them on the floor. Constantly refining, merging and splitting themes.
Step 16:	As clusters developed (a theme name with citations underneath) they were moved around the room to reflect the relationship between them. So, master themes were placed above sub-themes, or related themes were placed closer together.
Step 17:	Write a description of each theme.
Step 18:	Once completed, input participant initial, supporting citation and line number into a table of group analysis.

The next stage of analysis involved writing a 'participant and interview overview' for each participant. This felt like an important step in moving from the part to the whole as specified by Smith, Flowers & Larkin (2009) as a part of the hermeneutic circle. These 'participant and interview overviews' included a brief paragraph about the important demographics of each participant, their languages, clinical practice and background, as well as my feelings and reactions to the interview. The next stage involved creating tables and inputting the list of potential themes identified for each participant. An extract from a 'participant and interview overview' along with a table of potential themes can be seen below.

> *"She **used psychological knowledge and formulation** to make sense of many different situations related to her as a therapist and her clients. Being rejected, and being corrected, were both explored through psychological formulations of the **difficulties of the other person**, which meant that I felt there was very little exposure of how she felt about it and what she thought her role was in it"*

Pt	Potential theme (& description)	Citation	No.
R	**EXTERNALISATION** It's not me that people are frustrated or angry with.	*I shouldn't be taking it, as my trainee said, too personally*	699
R	**EXTERNALISATION** Betrayal is emotive and a violation of loyalties and allegiances.	*My language did betray me a little bit*	678

Reviewing all the individual themes together created the opportunity to refine the themes; merge them where necessary; examine the citations in relation to one another or split themes into further sub-themes. The mind-map presented an overview of theme names, with brief notes and line citations. This was to make it easier to view the interview 'as a whole' and observe how themes might relate to one another. Following this, the group analysis process began. This process was similar to the individual analysis; reading the citations and grouping the pieces of paper together in small piles, which were then looked at more closely to ensure that the citations 'hung together' to constitute a theme.

3.5 Quality standards in qualitative research

Various quality standards for qualitative research specified in the literature were considered in this study (Elliott, Fisher & Rennie, 1999). Situating the sample (a brief description of participants) has been presented to allow the reader to situate the participants. However, due to confidentiality it was not possible to specify the full range of characteristics that are attributable to each participant. The description of the analysis and results are presented with citations and examples of first hand data, including interview transcripts, examples of notes and memos, excerpts from my reflective material and tables that were used in the analytic process. Identifying relationships between themes and representing them diagrammatically were important for providing a "data based story" (Elliott, Fisher & Rennie, 1999), aiding coherence and integration in the overall final analysis.

During the analysis stage of the project, quality checks formed a integral part of the supervision meetings with academic supervisors. We discussed the names and the conceptualisation of different themes drawing on raw data from interviews. Through this process, I was able to gain alternative perspectives thus contributing to the trustworthiness and quality assurance of the findings. An alternative quality check could also have been established through *participant validation* which is an important quality measure in qualitative methodology (Parker, 2004). However, Kitzinger & Wilkinson (1997) comment that although this may be morally compelling, it should not be applied to all analyses, especially where analysis of meaning does not draw solely from the immediate perspective of the participant. As IPA involves the 'double hermeneutic' and the active interpretation by the researcher of what is said, participant validation is not recommended with IPA (Smith, Flowers & Larkin, 2009) and was not carried out.

3.6 Reflexivity and locating the researcher

By keeping a reflective journal, 'owning my perspective' (Elliott et al., 1999) and providing a pen portrait of myself, it was anticipated that the reader would be helped in making an informed opinion about my interpretation of the data, and the trustworthiness of the findings. This is of central importance in IPA due to the interpretative role of the researcher; the emotional investments and moral-political

standpoints of the subject should be made clear, following recommendations set out by Wilkinson (1998). It is hoped that the reflective elements of this project have facilitated a relationship between subjects rather than one between subject and object (Sciarra, 1999) and that I, and the project, also become a focus of study (Wren, 2004).

My reflective thinking in this project has been influenced by the notion of *fore-structures* (Smith, Flowers & Larkin, 2009), working at the *hyphen* (Fine, 1994) and creating an Other (Fine, 1994). *Fore-structures* in IPA analysis (Smith, Flowers & Larkin, 2009) refer to a researcher's ideas, values and ways of making sense of the world before embarking upon a project. Part of this may relate to an "already *pre-conceived* categorisation of the 'researched'" (Luttrell, 2010, p. 4). Exploring the hyphen (Fine, 1994) means that it is important to "discuss what is, and is not, "happening between", within the negotiated relations of whose story is being told, why, to whom, with what interpretation, and whose story is being shadowed, why, for whom, and with what consequence" (p. 72). My reflective thinking has also been informed by the literature exploring the way in which individuals, and researchers, create Others. This means that they construct the researched, or the Other, in a way that splits and expels complexities and dangers, which are then located elsewhere (Fine, 1994).

I am a 30 year old White, British born male and a coordinate English-Spanish bilingual. I learnt English through my infancy with my White British family in the UK and then learnt Spanish through education and living in Spanish-speaking countries. I live with my Spanish partner of 12 years in a Spanish speaking house, so live in a home that does not have my first language as its first, but in a community and society that does. Although I enjoyed my time living and working overseas, it was not always easy and I often felt frustrated and sad at the barriers I felt that I experienced, which I attributed to being "foreign". In my reflective journal at the beginning of this project, I wrote that during my time living abroad "*the person I thought I was disappeared. I became less confident, more of an introvert".* So after three years I decided to come back to the UK to pursue a career as a clinical psychologist. Since moving back to the UK I have seen my partner, who is Spanish,

live through similar experiences of feeling isolated and different at times due to having a non-native accent or not always understanding everything the first time. Seeing someone important to me live through this has , at times, been upsetting.

As a first year psychologist in clinical training I delivered cognitive behavioural therapy to a Hispanic client who did not speak English, only Spanish. Working therapeutically in Spanish made me consider the relationship between language and therapy as well as therapist experience. When I started this project some of my expectations were that that therapists would experience considerable differences when practising in one language compared to the other, particularly in emotion, which in retrospect may be based on the literature I had read.

Chapter 4: Results

4.1 Structure of the chapter

To begin each of the six participants is described. The chapter is then divided into two sections, reflecting two sets of findings. The first set focuses on the experience of working as a therapist in English as a non-native language, and includes all six accounts. The second set reflects the experiences of delivering therapy in a first language, for those four participants who had completed training in English.

4.2 Pen portraits

Anna

Anna had lived in the UK for five years and had decided to move to be with her partner, with whom she had children. Her self-report survey results suggested that her proficiency in English was Very Good (8), with a moderate foreign accent (5). In the survey, she indicated that she would be identified as a non-native speaker based on her accent (9 - maximum 10). She had completed all her training in her first language and had undertaken no formal training in English. She came across as a confident woman, who was sure of her abilities and seemed eager to show that the challenges of practising in English were manageable.

Betina

Betina had come to the UK initially to carry out therapy training, but had stayed because of better employment prospects. Her self-report survey results suggested that her proficiency in English was Very Good (8), with some foreign accent (4) and she thought she would readily be identified as a non-native speaker based on her accent (8). Although she had done some training in her first language, the majority of her training had taken place in English. She came across as calmly confident and as proud of her professionalism.

Karina

Karina had come to live in the UK after being offered a job here. She had since married and had children. Her self-report survey results suggested that her proficiency in English was Perfect (10), with some foreign accent (4) and she was identified as a non-native speaker based on her accent (5). She completed all her therapy training in English. She came across as warm and open to discussing times when she had felt vulnerable when practising in English.

Maria

Maria had come to the UK to study on a temporary basis, but had decided to stay on. Her self-report survey results suggested that her proficiency in English was Perfect (10), with almost no foreign accent (1) and she was almost never (1) identified as a non-native speaker based on her accent. She had competed all her therapy training in English. She was confident in her manner and often questioned the nature of my questions in interview.

Rita

Rita had come to the UK to follow her partner, who had come for professional reasons. She had since had children here. Her self-report survey results suggested that her proficiency in English was Good (7), with a heavy foreign accent (7) and that she was always identified as a non-native speaker based on her accent (10). Her initial training as a therapist was not in English, although she had taken some further training in English since coming to the UK. She came across as warm, but slightly less confident, than the other participants.

Sonia

Sonia had come to the UK to be with her partner. She had since had children here. Her self-report survey results suggested that her proficiency in English was Very Good (8), with some foreign accent (4) and that she was always identified as a non-native speaker based on her accent (10). Although she had completed some therapy training in her first language, she began training from scratch in English. It seemed important for her to emphasise the positives of working as a therapist in a non-native language.

4.3 Experiences of working as a therapist in English as a non-native language

Overall, three levels of themes were identified; master themes, main themes and sub-themes. There were two master themes. These were *Feeling challenged* and *Feeling equipped*. Over time there appeared to be a change whereby participants experienced an increased sense of *Feeling equipped*, and a reduced sense of *Feeling challenged*. There were three main themes reflecting this process in specific contexts; *Feeling accepted in the workplace, Achieving a sense of robustness in therapy* and *Achieving a sense of competence in therapy*. Each main theme had two-sub themes. All themes can be seen in Table 12.

Table 12: Experiences of working as a therapist in English as a non-native language

Master themes		Anna	Betina	Karina	Maria	Rita	Sonia
Feeling challenged		X	X	X	X	X	X
Feeling equipped		X	X	X	X	X	X
Main themes	Sub themes	Anna	Betina	Karina	Maria	Rita	Sonia
Feeling accepted in the workplace	Feeling embarrassment and self-doubt	X		X		X	
	Valuing relationships and support	X		X		X	
Achieving a sense of robustness in therapy	Feeling rejected and hurt			X			X
	Feeling compassionate and empathic			X			X
Achieving a sense of competence in therapy	Feeling disadvantaged	X	X		X	X	X
	Feeling special	X		X	X	X	X

4.3.1 Feeling challenged

This master theme was developed because across all the main themes there were elements of experiences, related to practising in a non-native language, that had been experienced as difficult, taxing or demanding. These challenges included making language mistakes in professional meetings, not understanding clients, experiencing

prejudiced attitudes from clients based on non-native accents and clients enquiring about participants' backgrounds .

Participants described feeling more challenged earlier in their time practising in English and they experienced an improvement in linguistic competence. Sonia and Rita's experiences reflected an improvement in language ability that was present in all accounts:

> *"My level of confidence and my competence of the language has improved throughout the years" (Sonia, l.523)*

> *"My English was eleven years back now, so was less, I'm sure I had less vocabulary, less understanding" (Rita, l.483)*

As linguistic competency improved and participants became more experienced in practising in English, the sense of feeling challenged attenuated. Speaking of their use of English in current practice, Maria and Anna made reference to the passing of time:

> *"No problem, I think now I don't really notice it anymore" (Maria, l.390)*

> *"I don't think that at the moment I would have many difficulties anymore because of the language" (Anna, l.707)*

4.3.2. Feeling equipped

This master theme reflected the ways in which, across different professional contexts, participants experienced a sense of *Feeling equipped.* Making sense of experiences was often achieved by drawing from their competencies as a psychological therapist. For example, experiencing prejudice in therapy meant that they could use this as clinical material to carry out therapeutic tasks and develop a sense of robustness; and experiencing communication difficulties or enquiries about

their background in therapy, meant that they had access to a range of special therapeutic tools.

Through giving specific meanings to the challenges, they could deal with them and develop a robust sense of *Feeling equipped*. The master theme reflected experiences of working with ease, which had two distinct, but related meanings: firstly, a lack of difficulty or impediment which seemed to result in feelings of competence:

> *"Obviously I come to work every day and do my job and it's not an issue" (Karina, l.1828)*

Across the accounts, participants felt that they could easily carry out the tasks of therapists. Secondly, the meaning attached to the experiences meant that there was a sense of *being* at ease; despite challenges they were not overly anxious or concerned, underpinning feelings of confidence. Anna spoke of her experiences of speaking in a professional setting:

> *"You build up that confidence and once you've done it a few times it's getting better" (Anna, l.1088)*

This sense of *Feeling equipped* had become more developed and robust for participants over time. Maria discussed her early experiences of delivering therapy with a non-native accent:

> *"when I first started, obviously I was a bit more nervous because I was less experienced, so there was more of a sense of, I wouldn't say intimidated, but nervous...Now I just, you know, I kind of know how to play it and erm to use it to my advantage as well as well so it is not an issue any more" (Maria, l. 250).*

So overall the two master themes are coupled together; *feeling challenged* attenuated over time and there was an increased sense of *feeling equipped*. Rita

spoke of the impression she aimed to give her therapy clients, highlighting *feeling challenged* and *feeling equipped:*

> *"I always kind of have the two messages for them: I can be clumsy and maybe I don't understand you so you will need to help me, but I am competent." (Rita, l. 1069)*

I will now go on to describe the three main themes in greater detail, providing descriptions of *Feeling challenged* and *Feeling equipped* in particular contexts.

4.3.3 Feeling accepted in the work place

This theme reflected participants' experiences in the professional setting outside of therapy, such as professional meetings and ward rounds. In these circumstances participants reported making language mistakes from time to time, or worrying that they may do so. Participants spoke of these experiences within a narrative which tended to end with colleagues being supportive.

Sub-theme: Feeling embarrassment and self-doubt

Making language mistakes in the professional setting was experienced as embarrassing. Participants also described feeling silly and clumsy; or nervous and small. Anticipation of making mistakes in upcoming meetings or professional situations led to feelings of self-doubt and anxiety. The feelings of embarrassment and self-doubt appeared to be rooted in a deeper significance; an underlying assumption that other professionals would evaluate participants' professional abilities *via* their language abilities . Karina spoke of making a language mistake in a multi-disciplinary ward round:

> *"So it made me feel really silly when I was trying to look so clinically mature and you know putting together this formulation. It made me feel really silly". (Karina, l.1443)*

Rita talked of her experience in professional meetings,

> *"I am capable of speaking the language…but I am sure that the fact that I sometimes clumsy, I come across with less, comp-, I come across as a less competent person." (Rita, l.634)*

In Karina's illustrative example, the feelings of silliness came from making this mistake in front of her professional colleagues, highlighting a tension between linguistic abilities, and perceived clinical abilities. Rita experienced her linguistic clumsiness as leaving her open to the accusation of incompetence. Across the experiences, there was a concern that other professionals would not distinguish between language competence and professional competence and may stigmatise participants based on the imperfect language skills. The binding of these two concepts together meant that, for participants, having their language competence questioned, potentially led to having their professional competence questioned.

Sub-theme: Valuing relationships and support

Coupled with experiences of *Feeling embarrassment and self-doubt* were experiences of receiving support and understanding from team members and other professionals. These were facilitated by participants through developing relationships, and asking for support or using humour. Supportive reactions from the professionals around them led to feelings of reassurance, inclusion, security and confidence. They were experienced as helpful, compassionate and supportive. This seemed to mediate the experiences of embarrassment or self-doubt, and contrasted with expectations of stigmatisation:

> *"people's reactions to it in many ways made me feel ok because they all came to me and said 'oh bless you'…so I think there was a sense of, there was, there wasn't, I didn't feel embarrassment. People didn't go out of their way to humiliate me and I appreciate that*" *(Karina, l.1446)*

Rita spoke of receiving some support with preparing documents in English:

> *"I felt supported as I was one of them, one, I didn't feel like I was this strange therapist, foreign strange therapist" (Rita, l.924)*

The appreciation of support and inclusion suggested that underlying participants' concerns were further anxieties about being rejected or excluded. Supportive reactions from colleagues were particularly valued because they fostered a sense of inclusion and unity, in the face of latent anxiety at the prospect of exclusion or stigma. Experiencing this inclusion in relationships, resulted in a sense of confidence. Even if they did make language mistakes, it would not lead to overwhelmingly negative emotional reactions, and they would also have the support of colleagues.

4.3.4 Achieving robustness in therapy

Two participants described being exposed to explicit prejudice from a client in therapy. There seemed to be a process that both participants went through to make sense of and deal with this experience.

Sub-theme: Feeling rejected and hurt

Initially, participants found the experience of meeting prejudicial attitudes in therapy difficult, upsetting, hurtful and offensive; in short they experienced *Feeling rejected and hurt*. This hurt arose because they felt they had been judged as not good enough, unable to be a therapist, by their clients:

> *"I think what hurts, or what I find irritating was that…because it's not your first language or because you are not born in this country, there is something wrong with you" (Sonia, l.878)*

They both recognised feeling hurt in the moment of facing prejudice; however, they prioritised the client material. Sonia told me how she dealt with the experience:

> *"..suspending between brackets* [the emotional impact on her] *if you want, it's like "what does it mean for her? What does, what is going on here?""(Sonia, l.854)*

Feeling the importance of staying with the client in that moment meant talking about the prejudicial attitude or behaviour, and not allowing personal reactions of emotions to become overwhelming. By carrying out what was expected of them in therapy, they used professional competencies, such as assessment and formulation, as a way of putting their personal reactions to one side. These professional competencies seemed to lend a sense of robustness meaning they could attend to the need of the client, in the face of upsetting personal circumstances and the associated emotions.

Sub-theme: Feeling compassionate and empathic

Using professional competencies also played a vital role in creating a sense of compassion and empathy for the client. Both Sonia and Karina discussed the clients' attitudes with them in therapy, in terms of dynamics within the therapy session or exploring what the prejudicial attitude might mean in the context of that individual's life. Through these discussions with the clients, which formed part of the assessment, Sonia and Karina developed formulations based on psychological theory. The psychological meaning of the prejudice drew from client life experiences and values, and emphasized traumatic or difficult experiences that the client had experienced:

> *"A pattern of behaviour where this individual tends to reject something before she's hurt…*so *in a way what she was doing with me was doing what she experienced constantly" (Sonia, l.805)*

> *"What happened actually was that they've had previous experiences... which were quite traumatic and that is part of where this stigma comes from so they've had an experience and they've just generalised and that was it*" *(Karina, l.1243)*

As can be seen from the above excerpts, through formulation both Sonia and Karina began to create meaning, to which the prejudicial attitudes were then attributed. As a consequence, they felt able to be compassionate and empathic towards the client, key elements for therapeutic work and being a competent psychological therapist.

The formulations also helped participants manage the emotional impact by de-personalising the attitudes that were channelled towards them. In doing so, they achieved a sense of robustness, despite initial feelings of hurt and rejection. Both of them highlighted this as different than with prejudice they have faced outside of the therapy room:

> *".. from a client and in the safety of the of my counselling room, it completely different if somebody... do it on purpose to be insulting" (Sonia, l.869)*

Sonia's reference to her therapy room providing *safety* illustrates the way that therapy skills and psychological thinking had enabled her to find a sense to the situation that reduces potential harm and upset for her. The role of being a therapist and the context in which they attitudes were experienced enhanced a sense of security. The meaning attached to these experiences meant that, despite initial negative emotional reactions , they could both continue to do their jobs with these particular clients.

4.3.5 Achieving a sense of competence in therapy

This main theme was developed based on experiences in therapy, and what they meant for participants. Different kinds of challenges or issues were experienced related to delivering therapy in a non-native language, leaving participants *feeling disadvantaged*. However, with time they discovered important ways in which delivering therapy in a non-native language brought special advantages to therapy, leading to *feeling special.*

Sub-theme: Feeling disadvantaged

This sub-theme refers to feelings mainly experienced in therapy earlier in participants' English speaking careers. Participants spoke of not always understanding clients or to struggling to express themselves as precisely as they would have liked in therapy. Anna spoke to me about a current client;

> *"If he would have come through the door at very very first, I think I would have missed a couple of indications, erm, certain informations, certain informations, how they're expressed, I wouldn't have picked up because my understanding wasn't as well as it would be now" (Anna, l.709)*

Self-perceived and actual imperfect English skills led participants to *feeling disadvantaged*, and this was contrasted with therapists working in English as a first language. Anna went on to discuss things she would say to herself in self-talk in therapy,

> *"I thought "actually I think you should have understood that, but you didn't because the language wasn't as precise as it should have been for you, but everybody else would have understood that"" (Anna, l.747)*

In addition to communication difficulties, enquires from clients about their background or country of origin, were considered something to be overcome by participants. They described speaking with a non-native accent, as something that would interfere with the aims and activities of their role as psychological therapist:

> *"What I do get you know all the time, still now, 'oh where are you from?' and yeah, and then I just say 'I'm* [nationality], *so you know, that is always around… Mm so if I can kind of just get that out of the way, at least we can get on with our work....if someone is always trying to figure out where you are from then really that gets in the way of doing the therapy. If that's consciously or unconsciously, so I'd rather just, you*

> *know, tell them and it's out in the open and we can get on with our work.*" *(Maria, l.171)*

Feeling disadvantaged did not impede participants from doing their job, but did require extra considerations, which were attributed to working in English as a non-native language.

Sub-theme: Feeling special

With time, participants began to experience *Feeling special* in their work as therapists. By working in a non-native language participants felt that they had access to special therapeutic tools, fostering a sense of competence. Participants described the way in which they felt able to facilitate therapeutic relationships because they were working in a non-native language, creating or maintaining a connection with the client during an engagement process or at times of a potential therapeutic rupture. Rita told me about a client who did not want to engage in therapy, but after some time asked if she was from Denmark:

> *"With this* [client] *we talked that was also the beginning then, he got interested and we talked a little bit of countries and cultures and language and things and, and so I think it gave them a position with me" (Rita, l.1132)*

For Rita, giving meaning to the situation in this way seemed to happen in the interview as we were talking. She went on to say:

> *"I never thought, as I am telling you, but I think maybe they connect with this, whatever we decide" (Rita, l.1146)*

Participants felt these conversations were therapeutically beneficial for the alliance. Aspects of their self were brought into the therapy room through the external markers, such as non-native accent or imperfect English. Across the accounts, participants seemed to embrace this and capitalise on it. By talking of language or

nationalities, they used these aspects of their self to be able to facilitate the ever-important therapeutic alliance, thus achieving therapeutic goals.

Feeling special came with time. As cited previously, when asked about her accent Maria used it is as a way to highlight dynamics in the session, but this had developed over time.

> *"Now I just, you know, I kind of know how to play it and erm to use it to my advantage as well" (Maria, l.254)*

Feeling special in therapy also came from participant experiences of self-perceived or actual imperfections in their English. Communication difficulties came to be understood as a way for power to be re-distributed between therapist and client:

> *"I wasn't sure what she meant so I had to say "can you tell me more about that?", so that was good moments of, therapeutic moments because there was something of empowering for her that you know, although I was the therapist who in her mind was sorted" (Sonia, l.489)*

The imperfections in language, meant that a special opportunity was created; the power that is inherent in occupying the role of a therapist, was reduced because she did not have access to impeccable English. As a result, participants felt that some of this power became accessible to the client, who spoke English as a first language. This created a sense of specialness for participants and seemed to come from a complex interaction between occupying the role of therapist or client, and being a native and non-native speaker. Through practising in a non-native language, the re-distribution of power became a backdrop for therapeutic processes.

In the accounts were examples of believing that working in a non-native language brought about fewer examples of assumed shared understandings with a client, fostering a sense of *feeling special*. Participants spoke about this in comparison with therapists who had English as a first language. They described a process whereby they would question a word or phrase that a client used, through not understanding

something or because they felt they had a greater awareness of how words were used in English compared with first-language speakers of English. This meant that it was easier for participants to gain access to idiosyncratic meanings for clients through the deconstruction or unpacking of what was said. This was seen as a unique aspect of working in a non-native language:

> *"There's a lot of me saying things like you really going to have to explain things to me because I you know I don't understand this so you really going to have to explain this, because I really want to understand exactly what you mean. In doing that sometimes you end up unpacking more than if you just obviously, you take, "yeah of course, I understand what you're saying" and because sometimes I have to go one step beyond that I actually may get a bit more information that other people probably wouldn't." (Karina, l.2038)*

Here the use of the comparative language demonstrated that there is a comparison process with therapists who have English as a first language, who would have *less* access to this meaning, or unpack *less* material. Rita and Sonia felt that this was a very special advantage to working in English as a non-native language:

> *"It has been my way of coping with being in another language, coping or making it in my favour the fact that I don't understand everything and I cannot assume everything, I am genuinely asking questions from a very non-knowing position…that's the advantage, the only advantage or the big advantage" (Rita, l.506)*

> *"I take it as a as a plus…I am more, if you want, pay more attention to details yeah? And that it could be a way of compensating the disadvantage of not being a native speaker Yeah? Be, because it's "what do you mean by that, what do you mean by that?" (Sonia, l.532)*

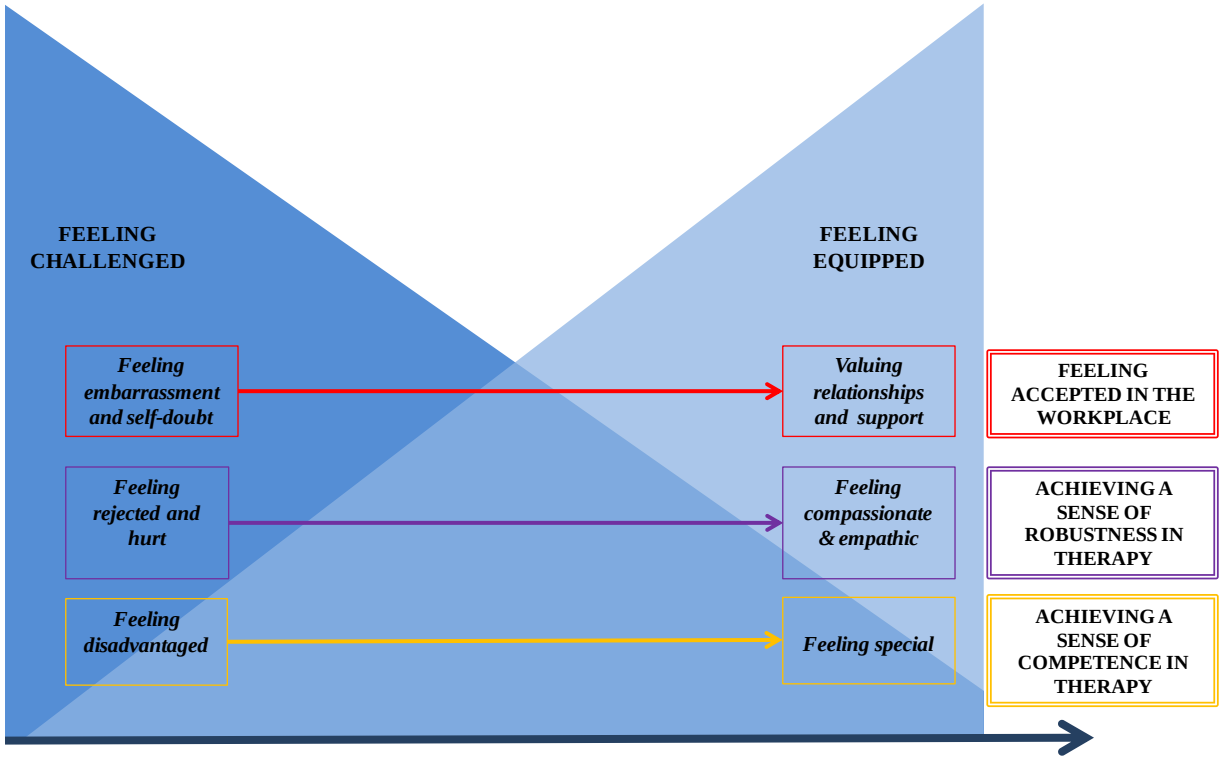
These citations reflect the ways in which *Feeling special* formed an important buffer or way of coping, helping make sense in a way that incorporated the experience of

Feeling disadvantaged, but not allowing it to become dominant. The outcome seemed to be feelings of specialness, when delivering therapy in English as a non-native language and *Achieving a sense of competence in therapy*.

4.3.6 Diagrammatical overview

Figure 3 aims to represent an overview of all themes and how they relate to one another. The blue arrow along the bottom of the figure reflects the passing of time. The two master themes are shown in the blue triangles. The area of the triangle labelled *Feeling challenged* decreases towards the right of the figure. This represents the decreasing sense of *Feeling challenged* over time. *Feeling equipped* is represented by the area of the triangle increasing towards the right of the figure reflected the way in which participants described an increasing sense of feeling competent and being able to deal with any challenges faced.

Figure 3: Experiences of working as a therapist in English as a non-native language



The three main themes can be seen in double outlined rectangles in red, purple and yellow, respectively. Each set of sub-themes, in the single outlined rectangles, is represented in the same colour as the main theme that subsumes them. Each main

theme reflected experiences in different contexts, and each , in turn, contained elements of *Feeling challenged* and *Feeling equipped*.

4.4 Experiences of delivering therapy in a first language.

These findings focus specifically on experiences of delivering therapy in a first language, for participants who had trained in English. These experiences refer to delivering therapy outside of the country of origin, with clients who shared their cultural background and first language. The majority of these experiences were in private practice in the UK. Only one instance was discussed where a therapist had picked up a referral in the NHS because of having a shared cultural background and first language with the client. The large majority of the clinical experience of the four participants was in English. Overall, three themes were identified (cf. Table 13).

Table 13: Experiences of therapy in a first language (having trained in English)

Themes	Betina	Karina	Maria	Sonia
Feeling awkward and less confident	X	X	X	X
Feeling a greater distance from the client	X	X	X	
Developing cultural dexterity	X		X	X

4.4.1 Feeling awkward and less confident

Participants experienced therapy sessions in their first language as stilted and awkward. This was attributed to delivering therapy with less fluency in their first language than in English. Maria described her use of her first language in therapy as "*rusty, a little bit wooden at times" (l.431)*. When asked what her experiences were of working in her first language, Betina said:

> "*Awkward, awkward, awkward. I don't like working* [in my first language] *because it's an effort for me because I'm translating from English into* [my first language]." *(Betina, l.963)*

This citation captures an experience shared across the accounts; that working in the first language included translating from English. This was demanding, and so participants had to make much more effort than when working in English:

> *"In my English practice you have some phrases that you start using and you have some fluency in your speech…and that is not there, it is almost like having I have to rediscover, erm, my fluency in* [my first language]*" (Maria, l. 533)*

It appeared that having clinical experience, and training, in English meant that participants had developed and established internal scripts of therapy in English, including vocabulary and set phrases to which they had direct access. Thus, they could work with fluency in English. By contrast, when working in their first language, such scripts were not as readily accessed. The result of this was that participants had to think more about the words and phrases they were using, and they experienced a reduced sense of automaticity or fluency in their sessions, making them feel awkward.

Feeling awkward in therapy influenced how skilful participants felt. They had moments of wondering if they could employ clinical skills, such as reflecting back, containing clients' anxiety or carrying out succinct assessments, as effectively as in English.

> *"I found it so hard when I was trying to reflect things back to her to use a language that made sense" (Karina, l.1883)*

They described feeling less confident than when delivering therapy in English, because they felt de-skilled. The excerpt from Maria below summarises this:

> *"Yeah, well, well, just feeling that I will not be as erm..as smooth I guess, you know that I will struggle to find words and yeah, and I think that the problem is if you as the therapist comes across as not confident it is very hard for the patient then to feel they can be safe. So I was quite*

aware of that so the nervousness was around for me to still let her know that I can hold her" (Maria, l.424)

For Karina and Betina, such experiences meant that they preferred working therapeutically in English than in their first language. They did not have the same sense of competence or mastery in the clinical setting when working in their first language , and this led to negative experiences, such as not feeling as comfortable, fluid or skilful.

For Maria, there was more to her sense-making. Like other participants, she felt awkward and de-skilled with therapy in her first language compared with English. However, as she spoke about this in interview, she began to identify some advantages, such as reduced fluency leading to paying greater attention to words used :

"I am more conscious of using certain words or looking for using certain words, which just thinking about it now I think the good thing might be that I am actually slowing it down because I have to slow down, the therapy has to slow down, and that might not be a bad thing" (Maria, l.541)

She went on to say:

"More space, for things to really happen so, erm, if I, you know if you become too used to the words and phrases that you use in therapy, you know, you might say them and not necessarily think about them, erm, I don't know, I have not thought about but I think that might be" (Maria, l.552)

So although Maria experienced feeling de-skilled and somewhat nervous about therapy in her first language, in interview she started to sense that not being *"too used to the words"* brought unique benefits. Her internal script of therapy was in English, and well-rehearsed. So, as she began to access, and

even re-write, this script in a different language, she paid more attention, and the pace of therapy slowed, allowing the dynamics to be given more space to develop and be examined.

4.4.2 Feeling a greater distance from the client

When working in their first language, three of the four participants spoke of a greater distance between themselves and their clients than when working in English. They felt there was a sense of formality in their first language sessions, with less intimacy. Participants automatically used their first language in a way that complied with cultural ways of behaving in their countries and cultures of origin, for example using second names:

> *"It's much more official and formal speaking in* [my first language] *and I think that has an impact on how I feel you know erm how I perceive the building of the therapeutic relationship… when you say "Mr. Whatever" even if you say "Mr. David, how are things?" you kind of put the barrier there" (Betina, l.985)*

This sense of formality made participants feel more distant from their clients and they felt this impacted on the therapeutic relationship. Feeling that it was more difficult to develop the therapeutic relationship because of the distance created through language, both Betina and Karina expressed a clear preference for working in English. Maria, however, seemed to understand the distance slightly differently. She had used it as a way of maintaining boundaries and appropriate distance in therapy with a particular client who, she felt, struggled to contain themselves and sought a closeness to her as the therapist:

> *"That is certainly a big difference, there is more of a distinct distance.. So I think it has been useful in* [my first language] *to use that as a tool*" *(Maria, l.834)*

For Maria, the distance was more tolerable because the meaning behind was not a challenge to therapy, but more of an asset. Consequently, by contrast with Betina

and Karina, she did not avoid therapy in her first language because she felt it enhanced her therapeutic abilities.

4.4.3 Developing cultural dexterity

Participants felt that having good cultural understandings of both the culture in the UK and in their country of origin impacted on therapy when working with a compatriot in the UK. They made reference to their own cultural learning when they first came to live in the UK. Participants described a process whereby there was an internalization of the cultural ways of behaving so that they too began to behave in line with these cultural practices. This can be seen in the extracts below:

> *"Now I would find it odd someone behaving like I thought I should have behaved four years ago" (Sonia, l.323)*

> *"the longer you live in a country… you will pick up the culture, and you kind of become naturalised" (Maria, l.986)*

This, along with their knowledge and experiences of the culture of their country of origin, resulted in describing a kind of cultural dexterity in therapy with compatriots. There were complex and intricate sets of cultural knowledge interwoven into the formulations, which in turn shaped how participants saw their role in therapy. Firstly, they had created a distinction between difficulties that were attributed to individual issues, and those attributed to culture. When discussing a clinical case of a compatriot, Betina said:

> *"I could see that it was more cultural thing rather than you know health anxiety, she didn't have health anxiety… it was more kind of because she just expects* [it]*, that was normal, that's how she was brought up" (Betina, l.868)*

Betina affords herself a position of being able to see the distinction between what was cultural and what was health anxiety, which she contrasted with the referrer, who did not have access to this cultural knowledge:

> *"so then the GP…just thought, you know, "Oh she has a health anxiety" (Betina, l.863)*

The feeling of having a cultural understanding of her country of origin helped Betina modify the formulation of what was happening for the client, and in doing so seemed to distinguish herself as being specifically skilled or knowledgeable, compared with those who lacked such cultural knowledge. Similarly, Maria made a distinction between individual and cultural difficulties, but factored into her formulation the differences she felt existed between the two cultures, as well as her own experience of learning about the English culture and living in it as a person from a different culture:

> *"I think it's perhaps it's nice for her* [the client] *to have another person who erm validates some of the experiences that she has here, as culturally rather than personality…that is what we experience as being* [this nationality] *in an English culture….in therapy that is something that you might want to talk about, but it is not a personality issue, it is a culture issue*" *(Maria, l.578)*

Through exercising their cultural knowledge, both Betina and Maria seemed to have avoided, in essence, a potential pathologising of their clients' difficulties. Clinical presentations that might have been attributed to internal, psychological disorders, were conceptualised as complex, cultural phenomena with the individual placed in a social, cultural and temporal context.

These more culturally sensitive formulations seemed to impact on how they perceived their role as a therapist. The following excerpts summarise how each saw her role:

> *"I was kind of maybe changing his perceptions to fit more with English perceptions" (Betina, l.1038)*

> "[I was] *helping her to see that it is not her fault or not her as a person, who will kind of get that or create that reaction…that it's something inherent in the culture" (Maria, l.616)*

It was as if they mediated between the two cultures, whilst the client, who appeared to be less experienced with respect to the cultural differences, made efforts to make sense of their respective difficulties. Although it was not expressed verbally in the interviews, I had a sense that participants felt protective of the clients, and that providing a safe space away from the cultural challenges was important to them. It was through *Developing cultural dexterity* that they could do this; an intricate knowledge of both cultures and experiences of having lived as a non-native person. This, along with their clinical skills, meant that they provided a safe, containing space where culture, as well as psychological distress, could be considered by both therapist and client.

Chapter 5: Discussion

In this final chapter, I first address the research questions. The findings of the study are then explored in the context of the wider literature, incorporating the literature reviewed in Chapter One and the wider psychological literature. I then provide a brief reflective account of the interviews and analysis, before exploring the strengths and limitations of the study and making recommendations for further research. I conclude by discussing recommendations for multilingual psychological therapists, their colleagues, supervisors and trainers.

5.1 Answering the research questions

1. *What are the demographic and linguistic characteristics and professional activities of a sample of multilingual therapists practising in the United Kingdom?*

The web-based survey provided a snapshot of the languages spoken by a sample of trainee or qualified therapists in the UK who identified themselves as being multilingual. One hundred and one multilingual therapists responded, representing 30 countries of origin and 39 spoken languages. Within this snapshot of data, all respondents had delivered therapy in English, although it was not a first language for over half of them. The majority of those who did not have English as a first language had received therapy training in English. In terms of professional activities, the results show that over half of the sample had delivered therapy in a second language and just under a fifth in a third language. A small proportion (3%) had delivered therapy in a fourth. The results indicate that working as a therapist in different languages in the UK is a contemporary and pertinent focus for research.

2. *What are the main experiential features of practising as a therapist in English as a non-native language?*

The IPA findings suggest that participants' experiences involved making language mistakes from time to time in the professional context and worrying about doing so. This was experienced as embarrassing. However, they experienced colleagues being supportive, and therefore participants felt accepted in the workplace. In therapy, some participants had experienced clients being openly prejudiced towards them. This made them feel hurt and rejected. However, they came to feel empathy and compassion for clients. Participants had also experienced communication difficulties in therapy, such as not understanding words used by a client. They experienced clients asking them about their background or country of origin, which they felt interfered with therapy. These experiences left them feeling disadvantaged . However, over time they came to experience something different; they experienced *feeling special* in therapy; being able to develop relationships with clients because they had enquired about their background. Participants also experienced learning more about what words meant for individual clients through asking for clarification.

3. *How do therapists practising in English as a non-native language make sense of these experiences?*

For participants, the meaning underlying their experiences was that with time a robust sense of being a competent therapist developed, a therapist accepted by clients and colleagues alike. Making language mistakes in professional settings initially meant that they felt they might be open to stigma and negative judgment of incompetence from others. However, it came to mean that there was an opportunity for feeling supported and included by colleagues, creating feelings of acceptance. Participants dealing with prejudicial attitudes in therapy, initially felt rejected as stigmatized or less worthy, but over time they were able to facilitate psychological work and create psychological formulations. This in turn meant that they had a sense of carrying out their role satisfactorily as a therapist, and were accepted by the client . *Feeling disadvantaged* in therapy reflected that

there were challenges and threats to a sense of competence, although, over time, the meaning of these experiences changed. *Feeling special* meant that participants felt that practising in a non-native language brought a host of special therapeutic tools to enhance or aid therapeutic processes, creating a sense of competence. Across all the different contexts, the meaning for participants was that they felt equipped and able to work as a psychological therapist in a non-native language.

4. What strategies are employed to overcome any issues faced?

To deal with the embarrassment from making language mistakes in meetings, participants made use of factors that mediated the negative experience (such as supportive reactions from colleagues). In therapy, participants overcame some of the challenges through using psychological skills and knowledge to formulate hostile attitudes or prejudice, thus alleviating their own negative emotional reactions. Participants also drew on aspects of themselves, such as a non-native accent, to develop relationships with clients. At times they also reframed experiences, attaching alternative meanings, such as *Feeling special* in the face of *Feeling disadvantaged*. Occupying the role of psychological therapist seemed to act as a buffer for some of the challenges when working in English as a non-native accent.

The responses from the respondents completing the web-based survey offered another source of data to answer this question. These findings suggested that respondents coped with challenges through learning new vocabulary, by reading or speaking to colleagues, being open with clients in therapy about potential difficulties in communication, asking for clarification and using non-verbal communication more often to draw meaning from conversations in therapy. There is some overlap between the two sources of data. Asking for clarification, for example, appeared in both sets of data, with the IPA analysis offering a richer understanding and a phenomenological and hermeneutic perspective.

5. *For those participants who had trained in English, how do these experiences, and the associated sense making, compare to their experiences of practising in their first language?*

The experiences discussed by participants referred to therapy with a compatriot outside of the country of origin. For those who had trained in English, delivering therapy in their first language was experienced overall as more challenging than in English. They felt less fluent and therefore more awkward and less confident in the application of their clinical skills. As a result they experienced the relationship with their clients as less intimate than those with whom they worked in English. A positive element of these experiences was that sharing a cultural background with the clients, and having a lived experience of the English culture, allowed for sophisticated cultural understandings and experiences to be incorporated into formulations. This impacted on how participants saw their role as a therapist; mediating between the two cultures in which the client found themselves.

5.2 Concepts of self

In the accounts of working in a non-native language, there were different ways in which participants used aspects of their experiences and their selves in therapy. Examples included using difficulties in understanding to access a client's idiosyncratic meaning, allowing their accent to open up conversations and thus develop relationships with clients or using imperfect English skills to reflect on and redress power dynamics. The general therapy literature draws attention to use of self as a therapist (Jennings & Skovholt, 1999; Combs, Avila, & Purkey, 1978). This use of self by participants is of particular interest because of the way in which participants made use of aspects of the self to further therapeutic activities. To make sense of these findings, I have found it helpful to consider participant self as multiple and complex, including a *personal self* that aids a *professional self*. In the psychological literature, there is a history of conceptualizing self as multiple (James, 1890; Rogers, 1961; Freud, 1976 and Cooley, 1964). Similarly, the postmodern perspective challenges the notion of self as unitary (Gergen, 1991; Hall, 1996). When I refer to *personal self* I mean the personal characteristics and experiences of participants that were discussed, such as being a non-native speaker, speaking with a

non-native accent and having less perfect English language skills than clients. I have used the term *professional self* to refer to their competencies and their role as a psychological therapist, incorporating therapeutic skills and theoretical knowledge of human nature and the therapist's role.

Participants had made sense of their experiences in such a way that highlighted the benefits of having access to special therapeutic tools because of working in a non-native language. These perceived benefits involved the *professional self* using aspects of the *personal self.* There appears to be a congruity between this and psychological literature. Individuals can attach meaning to their selves through personal identities, social identities and role identities (Brewer & Gardner, 1996). Role identity theory (McCall & Simmons, 1978) posits that the self-concept is based on the characteristics and expectations of specific roles occupied, which creates meaning for the individual and defines social position. Defining self in a work context is complex (Blader, 2007) as an individual may occupy numerous roles and belong to numerous social groups simultaneously (Roccas & Brewer, 2002), such as personal identity (e.g., diligent, competent), non-work social identity (e.g. gender, sexuality) and role identity (e.g. manager). Work-identity complexity refers to how individuals organize their different social and role identities cognitively in a work context (Caza & Wilson, 2009). The concept of work-identity complexity seems to map onto the complexity of different selves, with the *personal self* reflecting a non-work social identity, and the *professional self* reflecting role identity.

Co-activation is a term used to describe more than one identity being salient at a specific time and in a specific context (Ashforth & Johnson, 2001). Examining work-identity complexity, Caza & Wilson (2009) suggested that co-activation may result in a range of benefits in the workplace. They emphasize that work-identity complexity, and activation of more than one identity, in itself is not associated with either negative or positive experiences. Rather, it is people's reactions and perceptions of the complexity that influences how it experienced. In essence, it is how they make sense of the experiences that will dictate the valence of experience (Rothbard, 2001). The way in which participants had made sense of their experiences, meant that neither self was experienced as negative. The co-activation

of the *professional self,* carrying out the duties of a psychological therapist, and the *personal self,* for example being a non-native speaker of English, opened up a range of therapeutic benefits in therapy, such as developing therapeutic relationships or redressing power imbalances in therapy.

Over time, there seemed to be a process of using the *personal self* to aid *professional self* . To me it seemed that this was a form of bringing the two selves together. This seemed to contribute to experiences changing from *Feeling challenged* to *Feeling equipped* and having an array of special therapeutic tools. In a qualitative study with a sample of 100 psychological therapists, Skovholt & Rønnestad (1992) explored the professional development of psychological therapists over time, which the authors later refined (Rønnestad & Skovholt, 2003). They claimed that a central developmental task for psychological therapists, who are post-qualification and with numerous years of clinical experience, is to create an optimal therapeutic self which "consists of a unique personal blend of the developed professional and personal selves" (Rønnestad & Skovholt, 2003, p. 507). That is, the aim is to apply professional competence in a genuine, authentic way with a coherence in the professional/personal self. Academics taking a postmodern approach may suggest that this reflects the importance of having coherent sense of identity across contexts (Hall, 1990; Czarniawska, 2000). For participants, there seemed to be an additional aspect to consider in that their experiences of both *personal self* and *professional self* were shaped by delivering therapy in a non-native language. However, they found ways to bring them together meaningfully and create a blend of the personal and professional self, which fostered a sense of competence as a psychological therapist.

In their study of trainee therapists working in a non-native language, Morris & Lee (2004) identified a theme, *Time and Learning*, which referred to learning about language and culture. In the current study, I identified the development of *Feeling equipped* over time and I have made sense of this finding through theory of self, and professional identity. This difference in findings may be attributable to sample characteristics. Morris & Lee (2004) interviewed trainee therapists, whereas I interviewed qualified and experienced psychological therapists. It could be hypothesized that for participants in the Morris & Lee study, student or learner

identity was more prevailing than identity as a practitioner, or a professional identity, due to being at a different stage of their career. Furthermore, the participants in the current study gave retrospective accounts of the development of their role as a psychological therapist, which may have been less identifiable for those at the beginning of a professional career.

The development of a robust sense of professional identity over time was related to an increasing sense of competence and robustness as a psychological therapist. Although they experienced some challenges to working in a non-native language, participants could make sense of these through applying psychological theory and using psychological skills, highlighting the benefits they felt existed when working in a non-native language and which in turn could help mediate their emotional experiences. The role identity of being a psychological therapist seemed to act as a buffer for participants against the possible detrimental effects of feeling stigmatized or disadvantaged because of using a non-native language. Role identity in the work-place has been identified as an important resource (Baker & Faulkner, 1991; Callero, 1994) and the cognitive buffering hypothesis suggests that a greater sense of identity complexity leads to an increased sense of robustness, providing a buffer against the detrimental psychological effects of stressful life events (Linville, 1987). Similarly, *professional self* seemed to form an important resource in sense making and well-being for participants.

The findings of the current study may add some theoretical value to understanding the experiences of working in a non-native language. It could be that, for this sub-group of therapists, salient aspects of identity are those of psychological therapist and non-native speaker. This may be of particular importance given that external linguistic markers may make the identity as a non-native speaker a noticeable and salient aspect of self in therapy, leading to co-activation of identities.

5.3 Feeling competent in therapy

All participants experienced a sense of competence as psychological therapists. In the literature reviewed in Chapter One, working in a non-native language was perceived to bring a range of benefits. There were commonalities with findings in

the current study. These included asking for further clarification as positive (Lee & Morris, 2004; Costa, 2010), feeling that power imbalances were re-dressed through imperfect use of language (Kitron, 1992; Costa, 2010; Costa & Dewaele, 2012) and asking therapy clients what words meant helping with therapeutic aims (Karamat-Ali, 2004). Further commonalities include the perceived disadvantages or challenges when working in a non-native language that arose due to communication difficulties and making language mistakes, which impacted on therapist confidence (Verdinelli & Biever, 2009b), especially in the initial stages of experiencing them (Kitron, 1992). In the current study, a sense of competence increased over time. The difference between the current findings and wider literature concerns how the disadvantages or challenges are given meaning, from which the sense of competence develops (other contributing factors were improved language skills, see below, and professional development as a therapist, see above). The current study took a hermeneutical perspective in analysing the data, and thus sense-making was an important focus. This was not the case for the other studies or literature, which largely took either a purely phenomenological perspective, or a psychoanalytic perspective. This difference in perspectives may help explain the differences between the findings of the current project and those in the wider literature.

The sense of competence in participants' experiences is of particular interest as it was experienced in spite of sometimes feeling disadvantaged, rejected and hurt or embarrassed . Furthermore, competence is important for a sense of well-being. The competencies model (James, 1890) suggests that positive self-esteem is the result of being able to perform well in domains that are important to an individual. Similarly, consistent, successful outcomes have been seen to be related to increased self-esteem over time (Feather, 2006), as part of a considerable empirical evidence base for the competencies model (for example, Crocker, Karpinski, Quinn & Chase, 2003). Moreover, as previously discussed, a sense of competence seemed to be an important component in blending the *professional self* and *personal self*, which is an important part of the professional development in psychological therapists (Rønnestad & Skovholt, 2003). For participants, a sense of competence did not just come from professional and linguistic development over time, but from the way in which experiences were given meaning across different domains . It may be that this served

a psychological purpose. Psychological theory would predict that if an individual cannot experience a sense of competence in a domain that is significant for them, this would lead to a threat to self-esteem. As such, it may be that the way in which participants made sense of experiences served to create a robust sense of competence, and self-esteem. Crocker & Quinn (2003) suggest that much research has erroneously conceptualized self-esteem as a relatively stable and fixed trait. Instead, they propose that self-esteem "emerges in the situation and is a function of the meaning given to that situation for the self" (p. 159). This can be seen in the way in which Sonia and Rita spoke about not understanding in therapy; it became a *plus* or *advantage,* a way of coping in the face of challenges when working as a therapist in a non-native language. The importance of meaning can also be seen in the way that potentially challenging experiences for participants actually meant that new opportunities were opened up for feeling accepted, robust and competent across different domains.

The commonalities between the literature reviewed and the current findings suggest a robustness and potentially wide applicability to the finding that, although initially communication difficulties may impact on therapist confidence, multilingual therapists perceive a range of advantages to working across languages. The practical value of these findings is that multilingual therapists and their supervisors need an awareness of the ways in which working in therapy in a non-native language can bring benefits. This may help address anxiety for multilingual therapists, particularly for those who are less experienced and/or who have a less developed sense of professional identity, which can act as an important buffer.

5.4 Dealing with expected or actual stigma

Participants spoke of experiences relating to expected or actual stigma in professional contexts and in therapy. At times this was explicit, such as being the target of attitudes, whilst at others it was more implicit, such as feeling that their clinical ability may be questioned because they spoke English as a non-native language. Its appearance here may be a result of the context of participants' experiences, that is, working in a non-native language outside their country of origin. Much of the systematic qualitative inquiry from the USA examines the experiences

of Spanish-English bilingual therapists (Verdinelli & Biever, 2009a; Verdinelli & Biever, 2009b; Castaño, Biever, González & Anderson, 2007). In this context, there may well be less scope for stigma based on language because of the higher incidence of shared backgrounds or language between therapist and client. Similarly, research by Costa (2010) and Costa and Dewaele (2012) examined the experiences of multilingual therapists with multilingual clients, which is also a context in which stigma towards the therapist may be less expected. The findings of the current study suggest that for those working in a non-native language, stigma may be a relevant consideration for therapy, as well as for the well-being of multilingual therapists working outside their country of origin and in a client's first language.

Stigmatization comes about if a person is deemed to possess a characteristic that is associated with a devalued social identity in a specific social context (Crocker, Major & Steele, 1998). Link & Phelan (2001) "apply the term stigma when elements of labelling, stereotyping, separation, status loss, and discrimination co-occur in a power situation that allows the components of stigma to unfold" (p. 367). Stigmatizing marks are signs, such as group membership, physical appearance or behaviours, that can lead to stigma and can be used for a basis of excluding the stigmatized. In multilingual contexts these can be speaking with a non-native language or having imperfect expression or comprehension in a language. Often dominant political and popular discourses consider non-standardized varieties of a language to be inferior (Collins, 1999), due to monolingualizing ideologies (Blackledge, 2000). Research suggests that speaking with a non-native accent can create negative experiences for speakers due to perceptions that others will stigmatize them (Gluszek & Dovidio, 2010; Derwing, 2003; Vorauer, 2006).

Those who discussed experiences of anticipated expected stigma in the workplace made use of professional relationships to mediate any negative emotions; this appeared to alleviate latent fears of exclusion and rejection. The importance of relationships in the workplace for support and a sense of acceptance were consistent with the findings of Verdinelli & Biever (2009a; 2009b). In their study, Verdinelli & Biever (2009a) identified the theme of *Feeling isolated and rejected,* which referred to perceptions that monolingual colleagues did not understand the challenges of

working across languages, with a sub-theme of *Coping via peer support and networking.* The latter theme seems similar to *Valuing relationships and support* in the present study, although there are important differences between the two samples. Verdinelli & Biever's (2009a) sample comprised Latino/a therapists working in the USA and support was sought from other bilingual therapists. This was not raised by participants in the current study who sought support from colleagues in general. This difference may be attributed to context and opportunity. It is likely that the prevalence of Latino/a, bilingual therapists in the USA is greater than multilingual therapists of European descent practising in English as a non-native language in the UK, thus creating greater accessibility to this kind of support.

For Anna, Karina and Rita making use of relationships in the workplace created a feeling of inclusion, which ameliorated a sense of humiliation and potential rejection from feeling judged by their language skills. Problem-focused coping (Folkman, Lazarus, Gruen and DeLongis, 1986) has been used to explore adaptive reactions to stigma (Miller & Major, 2003). This form of coping has its aim as changing the relationship between the person and environment and in doing so eradicating the cause of stress, which could be applied to participants' experiences of using relationships to feel accepted. Leary & Downs (1995) suggest that self-esteem fluctuates in line with the acceptance or rejection of other people, and a positive sense of self is therefore rooted in social relationships and acceptance (Leary, 2007). This may help explain the latent anxiety at the prospect of rejection. Experiences of acceptance from colleagues in the workplace seem to be important when working as a member of a linguistic minority or working in a non-native language; this is highlighted in the current findings and those of the literature reviewed in Chapter One. Regardless of setting then, it is important to feel included and supported, particularly in the face of challenges, in the workplace. On a practical level, this may mean that specific attention should be paid to opportunities for developing professional relationships. Furthermore, training monolingual staff in the potential therapeutic benefits of working in a non-native language may mean that potential assumptions could be challenged, particularly the assumption that language and clinical skill are one and the same. That said, it is important to note that participants

did not report experiencing explicit stigma in the workplace, but that they held expectations of it.

Both Karina and Sonia reported experiencing prejudice and stigma in therapy, and felt that they had effective ways to cope with this. Although only two participants of the sample spoke of this, it is important to further explore the experience and meaning making in relation to wider theory for two reasons. Firstly, stigma in therapy may pose a significant threat to the therapeutic relationship, which has a central role in positive therapy outcomes (Lambert & Bergin, 1994; Wampold, 2001; Norcross, 2010). Horvath, Del Re, Flückiger, & Symonds (2011) write that "Therapists' non-defensive responses to client negativity or hostility are crucial for maintaining a good alliance. Therapists have to develop the ability to neither internalize nor to ignore clients' negative responses" (p.15). Secondly, experiences of stigma are a considerable threat to self-esteem (Twenge & Crocker, 2002; Jost; Quinn & Crocker, 1999, Branscombe, Schmitt & Harvey, 1999; Baumesiter & Leary, 1995). It is perhaps surprising that there is a lack of guidance on how to deal with explicit prejudicial attitudes in therapy (Bartoli & Pyati , 2009).

Through the use of competencies of the *professional self*, both Sonia and Karina used psychological assessment and formulation to provide context to the stigma they faced in therapy. This context was used to create a sense of compassion about the clients' difficult life experiences, which in turn served as an explanation for the clients' attitudes. They felt this helped them maintain their therapeutic relationships in the face of feeling hurt and rejected. This resonates with Bartoli & Pyati (2009), who recommend that one should strive to "decipher the multiple meanings embedded in clients' racist or prejudicial comments and address them therapeutically" (p. 147). Sonia and Karina felt that they did this and engaged their clients effectively. However, Bartoli & Pyati's (2009) recommendation focuses on managing the impact on therapy and therapeutic processes, but not on managing the impact on the therapists themselves.

Experiences of stigma were difficult for Sonia and Karina, who felt rejected and hurt. Major & O'Brien (2005) proposed a model which suggests that stigma

increases exposure to identity-threatening situations that are potentially stressful. The stigma-induced identity threat model encapsulates a theory of stress and coping (cf. Lazarus & Folkman, 1984) as a way to understand reactions to stigma. According to Major & O'Brien's (2005) model, an identity threat would come about if an individual appraises the demands of the stress created by experiencing stigma as harmful to his or her identity, and it *surpasses* his or her coping resources. It may be that experiencing stigma in therapy was a threat to both professional identity, as it threatened the important component of being able to form a therapeutic relationship with a client, and a threat to personal identity, as it represented a rejection. However, by using psychological skills and knowledge they could make sense of the prejudice and stigma, depersonalize it and thus manage the negative emotional impact. This allowed them to continue to engage with the client without overwhelming negative emotional experiences. It may also have strengthened a sense of *Feeling equipped*, through managing the situation and continuing to work with the client. This is an example of *professional self* acting as a buffer against stressful situations. As such, experiencing the stigma was neither appraised as harmful to identity as a psychological therapist (*professional self*), nor did it surpass their coping resources. It is of interest to note that both Sonia and Karina contrasted these professional context experiences to those outside of therapy that felt more hurtful. This could be further support that the *professional self* is an important buffer in the workplace in the face of stigma. The practical implication of the present findings is that experiencing stigma in therapy may be an important consideration for those practising in a non-native language, both for understanding a client's difficulties as well as for the well-being of the therapist.

5.5 Fluency and attention to language

Participants reported that in the context of therapy their English fluency improved as time went on and their confidence increased. At the time of interviews, some described hardly noticing any longer that they were working in a non-native language because of their improved fluency. Improved fluency over time tallies with the theme *Time and learning* that emerged in Morris & Lee's (2004) study. They interviewed trainee therapists working in the USA in English as a non-native language. This theme reflected the process of learning about language over time. In

the present study, not only was time and learning identified, but so were participants' perceptions of how this impacted on their experiences of therapy, namely influencing the degree of attention they paid to language. This feature was not identified by Morris & Lee (2004).

Carlson, Sullivan & Schneider (1989) refer to fluency, in the context of non-native language acquisition, as an automatic, procedural skill, which Schmidt (1992) further clarifies as being automatic *doing*, which does not require much effort or attention. In their definition of fluency, Wolfe-Quintero, Inagaki & Kim (1998) claim that control of language production improves as a learner automatizes the process of gaining access to information. Participants experiencing their use of English as increasingly fluent could therefore be conceptualised as it becoming increasingly automatic . In line with these definitions of fluency, these participants' experiences and attributions fit with cognitive models of attention in automatic and conscious processing. The basic premise is that automatic processing is quicker, less demanding on cognitive resources, less available to conscious awareness and often occurs in well practised tasks. By contrast, controlled processing is limited and requires more attention (Shriffin and Schneider, 1977; Norman & Shallice, 1986; Logan, 1988).

Paying specific attention to language in therapy has been highlighted as helpful therapeutic tool (Rivett & Street, 2009; Besley, 2001) as a way to unpack meaning, to find more positive perspectives and to alter thoughts, feelings and actions. There is a compatibility between the theoretical perspective on attention to language in therapy and participants' interpretation of experiences - there are therapeutic benefits to be had through increased attention to use of language in therapy. However, as fluency in English increased, participants felt they paid less attention to language, barely noticing it, which we can understand in terms of psychological models of attention and processing. This would suggest a possible detrimental impact on the therapeutic tool of greater attention to language. The practical implication of this would be to consider ways in which multilingual therapists can maintain attention to language and its use in therapy as their fluency improves. Moreover, these findings may help therapists working in a first language, having

trained in that language, to consider their own attention to language and its use in therapy.

Fluency was not only discussed in relation to English. Those who had trained in English felt awkward and less fluent when delivering therapy in their first language, which meant they felt less confident. This suggests that fluency in therapy may be distinct from fluency in a general context. This is mirrored by other findings, discussed in Chapter One, that being able to speak a language does not equate with being able to use one's knowledge and skills as a therapist in this language easily (Biever, Castaño, de las Fuentes, González, Servín-López, Sprowls, & Tripp, 2002), and that multilingual therapists feel that they have a "professional language" which might not be the same as their first language or language learnt from infancy (Costa & Dewaele, 2012). As such, it seemed that this sub-group of the sample had a "therapy first language", that did not coincide with their first language, in which they had greater fluency and felt more comfortable in therapy. This suggests a robustness to the recommendations in the literature that assumptions should not be made about the ability or confidence of therapists to practise in languages in which they have had no training.

Maria felt that reduced fluency in her first language meant that she paid increased attention to language use in therapy. Other participants also experienced challenges in a first language. This suggests that *fluency in the specific context in therapy* is an important consideration, independent of whether the language is a first or non-native language. It may also suggest that differing degrees of fluency impact on experience and subsequent meaning making, possibly leading to a greater feeling of or actual attention to language.

There is a further finding that may support the link between fluency and attention to language in therapy. The interviews with those who had trained in the languages of their infancy did not include rich data about practising in these languages. One of these participants had trained bilingually (as she had learnt two languages from before the age of four, although still considered herself to have a first and second

language). She said that although her training had taken place in two languages, she had not considered this until the research interview[5].

> *"It's interesting that I didn't think of this. I didn't think that I've received training in different languages. As I think, yeah, I didn't think of that."*

This did not appear in the analysis as no further data were available to constitute a theme, but it does illustrate an important consideration. It may be that when the language(s) of infancy and training are the same there is less explicit attention to how language is used. When the language(s) of infancy and training are different, language use may become a focus of attention, because of the increased cognitive demand.

Similarly, participants felt awkward in therapy in a first language, having trained in English. One explanation for this may be that schemas and scripts of delivering therapy are learnt, for example in English, via training. It follows that participants were used to developing therapeutic relationships, and accessing therapy specific verbal and behavioural repertoires, in English. If they then try to carry out these tasks in a different language, they may experience a disruption in their access to these scripts, thus making it harder to experience an comfortable and emotionally intimate, but therapeutically professional, connection in therapy . This may lend further understanding to the theme of *Feeling a greater distance from the client* when working in a first language.

Moreover, one might therefore hypothesise that the *professional self* had English as a dominant language for those who had trained in English, and so is therapeutically multilingual to a lesser extent. Caza & Wilson (2009) define work practice schemas and internalised scripts as how an individual should carry out their work, and a script for action. In the context of multilingualism, the principle of encoding specificity

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[5] For the sake of anonymity, this citation has not been attributed to a specific individual, as being a compound bilingual could render her more identifiable.

predicts that if the language is the same at encoding and retrieval then information is more easily accessible (Marian & Neisser, 2000). This may help explain the difficulty in accessing therapy scripts in a non-training language, and the consequent difficulties in applying clinical skills. The practical implication of this is that those working in a language in which they did not train should be provided with the opportunity to develop internal scripts and schema in the language in which they are going to practise. This may come from taking part in role plays, or attending training and conferences, in the target language.

5.6 Cross cultural mediators

Betina, Maria and Sonia all described a process of learning and internalizing cultural values from the UK, and as such had developed a kind of cultural dexterity which they used when working with compatriots in their first language in the UK. This impacted on how they saw their role and task in therapy and it gave them special insights into clients' experiences relating to culture as opposed to pathology or the individual. This seems similar to the description in Costa's (2010) paper of multilingual therapists as a bridge for multilingual clients from the country of origin to the host country. In that study, the participants described clients as relating to their "foreignness". However, in the present study participants focused not on such a connection, but more on how they participants saw their role. This was attributed to having a knowledge of both cultures, rather than having a "foreignness" in common. This different emphasis is likely to relate to the shared country of origin. Participants contributing to the theme of *Developing cultural dexterity* saw their roles as different depending on the language in which they worked, the commonalities with the client and the context of a client's experiences. Also, in the current study the process of developing cultural dexterity when working with compatriot in a first language seemed to be the result of the therapist's own process of acculturation in the UK.

Tadmor & Tetlock (2006) developed the Acculturation Complexity Model, which suggests that people who have internalized values and scripts of more than one culture are "biculturals". This means that they have increased cognitive complexity, i.e., "the capacity and willingness to acknowledge the legitimacy of competing

perspectives on the same issue and to forge conceptual links among these perspectives" (p. 174). Betina, Maria and Sonia felt they had access to alternative perspectives in which cultural experiences in the UK formed an integral part. At times this was even held in contrast to other healthcare professionals who did not have such access. Tadmor & Tetlock (2006) highlight other aspects of the perspectives of those who are considered to be "biculturals", such as disconfirming information and engaging in more effective information search, both of which are key when working as a psychological therapists. This mirrors a concept introduced to the therapy literature by Krause (1998). She drew on a philosophical notion, doxic experiences, put forward by Bourdieu (1990). This refers to cultural experiences and practices which are so taken for granted that they are not open to scrutiny or examination, and so remain unquestioned. Krause (1998) highlights the therapeutic benefit that can be brought from putting unseen assumptions of the therapist under scrutiny. Such scrutiny can be facilitated through therapy across cultures. An example of this may include Betina's client, diagnosed with health anxiety by the GP, but who Betina felt was actually dealing with cultural difference in healthcare practices between her country of origin and the UK.

The present study also highlighted the way in which this sub-group of participants felt they mediated between two different cultural worlds for clients. This is a further commonality between these findings and the implications of the Acculturation Complexity Model. Tadmor & Tetlock (2006) write:

> "Biculturating individuals' broader cultural knowledge and higher integrative complexity may allow them to act as intermediaries, alleviating the difficulties associated with cross-cultural communication" (p. 186)

This seems significant in that participants felt that, as psychological therapists, they were helping mediate between two cultural worlds. One possible practical implication of this is in relation to the needs of individuals entering a new culture and country. It may be that to have a therapist, or even support network, that understands both cultural worlds would be beneficial in making sense of differences and the impact on the individual. This may be particularly important when the

transition from one country or culture to another is sudden, stark or under traumatic circumstances, as is often the case with refugees and asylum seekers. However, it should not be assumed that a therapist who shares a cultural background with a client would always be more beneficial than one who has a different cultural background. As Krause (1998) suggests it is important not to assume, because of perceived similarities with clients, that our cultural understandings are a reality. This may mean that constant reflection and trying to increase awareness of therapists' own assumptions, particularly in the context when both client and therapist share a background, may be important .

5.7 Reflexivity

To assist me in thinking about my own contribution to the conversations I had with participants and how I influenced the analysis, I have drawn on the notion of *fore-structures* (Smith, Flowers & Larkin, 2009), working at the *hyphen* (Fine, 1994) and creating an Other (Fine, 1994). Before starting the project I think I held an implicit assumption that working in a non-native language might be associated with challenging experiences. I brought this to the hyphen, the space between the participants and me, based on my own experiences of living and working in a non-native language. This can be seen in my motivation for the study discussed in Chapter Three – to arrive at some findings that could help or support those working in English as a non-native language. An unseen aspect of myself may have been a belief that those working in English as a non-native language needed help and if they did, that I, or the findings, could provide it. Fine (1994) might suggest that I had created an Other that was weak and in need of help and a position for myself that was positive, as altruistic "helper".

Amongst other aspects of experience, I became interested in the challenging aspects of their work in English and inquisitive about anxieties that they might experience. I think I saw these as the aspects that could be helpful to extrapolate and learn from, for others working in non-native languages. Moreover, as a psychological therapist myself, my default position may have been to try to understand anxieties, challenges and difficulties. As participants described them to me, they also told me about the different ways in which working in a non-native language was helpful, or a "non-

issue", as they no longer noticed it. And so there emerged two aspects of experience; challenges and being equipped. Through these interactions, both meaning and knowledge was co-constructed between us, from which the findings have been developed.

I have English as a first language, like many of the participants' colleagues and clients, and I wonder if the processes in the interviews were almost a live example of their lived experiences. I felt there was a process of participants helping me see the complexity in their experiences, in who they were and the work they did, a sense of communicating an alternative and more complex perspective than anticipated by me. In a way, this mirrored many of the experiences at work they described to me – a process of re-negotiation through which both aspects of self became acknowledged and entwined. This process continued for me through analysis as I tried to understand their experiences and came to see the complexity in their sense of self as a therapist working in a non-native language.

Whilst I do not claim that the themes I identified and presented are free of my fore-structures and assumptions (if they ever could or should be), I hope that, by reflecting on the process of the interviews, I have provided the reader with some insight into the assumptions and experiences which may have impacted on the project from inception to completion.

5.8 Strengths, limitations and future research

Discussion of the strengths and limitations is focused on the IPA part of the study, given that the web-based survey was critiqued earlier (see p. 50). This is the first study, to my knowledge, that has attempted to address the experience of working as a therapist in English as a non-native language in the UK.

Recruitment and sample

Nationwide recruitment allowed issues of homogeneity to be considered resulting in a sample of co-ordinate multilingual qualified therapists who were all practising in the UK in English as a non-native language. The difference in training language has allowed for a further analysis including four of the participants. One limitation is

that the difference in training background introduced some heterogeneity in the analysis focusing on practising in English as a non-native language. A further limitation is that the findings are applicable to this sample of six qualified, multilingual therapists, who were all female, of European descent and migrated due to pull factors (a preference for moving to the host country) as opposed to push factors (having to leave the country of origin). They were also experienced therapists, and as such perhaps not all the findings would be applicable to those who are earlier in the process of *Feeling equipped*. This means that caution should be taken with generalisability of the findings to other multilingual therapists.

Data collection

The use of semi-structured interviews allowed for a flexible approach that was time-efficient and could produce rich data. It was anticipated that this would help reflect salient and important experiences for the participants, as opposed to being solely dominated by the researcher agenda. This has resulted in new areas of experience for therapists working in a non-native language being discussed, such as professional identity and experiences of stigma.

Like all accounts of events and experiences, those provided by participants in this study are partial constructions. This may be for various reasons. Firstly, memory of accounts is always partial, incomplete and re-constructed. Secondly, the questions I asked in interview may have meant that certain experiences were not prioritised or considered to be important by participants. Thirdly, participants may have made decisions, consciously or otherwise, to represent themselves and their experiences in certain ways as a means of impression management.

Analysis

During the analysis, I had regular meetings with my academic supervisors, who are both experienced clinical psychologists. I consistently used examples of raw data and interview transcripts in these meetings to assist in quality control and trustworthiness, as well as to gain alternative perspectives on how I was making sense of the data. One limitation was that I did not start my analysis until the data collection had been completed. This meant that I did not have the opportunity to

hone in on experiences that had been identified through analysis of a previous interview. An example of this includes experiences of explicit prejudice in therapy. I identified two main aspects of self in my consideration of the findings. However, self and identities are fluid and multi-faceted and it is naïve to assume that these two aspects of self discussed here can capture the entirety of a participant's identity. We did not discusses other aspects of identity, which may have included being a mother, academic, researcher, wife, etc. This is due to the research focus on being a multilingual therapists and the data collection and analysis centring on this focus. Moreover, it may be that my sense-making, resulting in the *professional self* and the *personal self*, was influenced by this focus.

Reflexivity

I have attempted to use open and honest reflection to enable the reader to make an informed decision about the trustworthiness of the findings, trying to acknowledge how I believe I, and my fore-structures, have influenced the interviews and findings. A limitation may be that much of my reflection occurred after having designed the project, and carried out the interviews meaning "unseen" fore-structures will have influenced the project throughout, although attempts have been made to make them as explicit as possible.

Future research

Future research could aim to develop a more intricate understanding of developmental processes over time and how these impact on experiences and sense-making for multilingual therapists. It may be helpful to try to elucidate the impact of two different concepts on experience – time spent practising in a language, and the language of training. A study design that would be of interest would be a longitudinal, qualitative design with multilingual trainee therapists. This would enable exploration of issues such as changes over time in *therapy-specific fluency*, professional self and feelings of competence. Future studies may wish to aim for homogeneity in terms of whether participants trained in their first language or a non-native language.

It may also be beneficial for further research to explore the experiences of multilingual therapists with different demographics. Important groups may include male therapists who are multilingual. Alternatively, qualitative approaches to dealing with explicit prejudice or stigma in the UK could help to develop the preliminary findings in this study. Finally, it would be fruitful to develop an understanding of clients' experiences and meaning making when in therapy with a multilingual therapist, potentially with a focus on contributing factors to creating a positive therapeutic relationship.

5.9 Recommendations

These recommendations are made tentatively with an awareness of the limited generalisability of the findings of the study.

1. Participants in this study felt that there were a range of advantages to working in a non-native language, which facilitated therapeutic processes. An awareness of these different benefits may help multilingual therapists working in a non-native language gain access to different, special therapeutic tools. This may also be important for those who supervise therapists working in a non-native language, particularly for supervisees who are at the earlier stages of their clinical career. It may be helpful to re-frame challenges as useful, or tempered by the range of benefits. This may help contribute to a developing sense of competence and confidence over time in the supervisee. Moreover, those who train therapists, monolingual and multilingual, could take these therapeutic advantages into account to help trainees explore the concepts and tools in their own practice. This could be done by asking therapists working in a non-native language to teach on training courses about their experiences.

2. Multilingual therapists and their supervisors may wish to pay specific attention to how multilingual therapists experience different aspects of self in therapy. Some may find it helpful to structure their thinking by considering a *personal self* and a *professional self* and how working in a non-native language may be used in, and impact on, clinical work, including benefits and challenges for therapeutic processes.

3. Experiences of actual or anticipated stigma in different contexts were reported by participants. Participants used their reactions and feelings in therapy sessions for understanding their clients in context. This means that discussions about prejudiced attitudes in therapy may be important in supervision for formulation, and may also allow for an integration of professional and personal experience. Moreover, sense making through the use of psychological theory helped mediate the personal impact on the therapist and help therapist well-being.

4. For some, professional relationships and a sense of inclusion helped mediate feelings of embarrassment at language mistakes in the professional context. Opportunities for developing and maintaining professional relationships in the workplace may be helpful to deal with this experience.

5. Training providers and supervisors may wish to consider how the needs of therapists working in a non-native language may change over time. For those early on in their careers, for example, it may be important to provide support in language development, such as comprehension and expression in therapy. This may be done through watching videos of therapists working in a first language, or observing supervisors work. It may also be helpful to explore challenges experienced in therapy as potential opportunities, through the use of self as a therapist. This may also contribute to a developing sense of competence and confidence contributing as robust sense of professional self (which acted as a buffer at times). For those who work in a non-native language and are more experienced, it may be helpful to reflect on ways in which improved language proficiency may impact on therapeutic processes, for example potentially reducing access to idiosyncratic meaning for clients.

6. Working in a first language having trained in English was experienced as awkward. Participants felt that this impacted on their ability to use clinical skills and on the relationship with the client. It may be advisable for therapists working in a non-training language to have opportunities to develop internal scripts and schemas in the language in which therapy is to be carried. Exercises,

such as role plays, or attending conferences in the relevant language may assist with this.

7. Those who had worked with a compatriot outside their shared country of origin and in a first language, felt that they had a role in therapy of helping the client mediate cultural experiences in the new milieu. A possibility is that it is helpful for clients to have a therapist who understands the different cultural worlds which they occupy. However caution should be taken with therapists' assumptions of understanding when client and therapist share a cultural background.

5.10 Final reflections on my learning

I would like to finish with a short reflection on what the participants, and carrying out this project, have taught me about myself and my own professional practice. Over the last year, when in a sessions with a client, I have often thought of the words of Sonia who said that she asked "What do you mean by that? What do you mean by that?" when she didn't understand, and in doing so got to the client's own, idiosyncratic meaning. This is just one example amongst many, illustrating the way in which meeting the participants has created new perspectives for me on important therapeutic issues, such as language, stigma, competence, robustness, anxiety, acceptance and relationships.

Through this work, and hearing the participants' stories, I have thought about my own assumptions about what a client says in therapy, as well as about my assumptions about working and/or living in non-native languages. For me, hearing the participants' stories has opened up a range of possibilities and opportunities of different ways of being through speaking different languages. They have also taught me to think about my own self, in English and in Spanish, and the multiplicity of my identity. As a psychological therapist I have tried to use the emotions and experiences of the Spanish-speaking David, who felt less confident and somewhat lost at times, to help me have different understandings of clients' experiences. For me, this learning has come about through exploring and learning about the

experiences of those who work as psychological therapists in English as a non-native language.

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Appendix I: Search strategy

1. Literature Search:

1.1 Search terms

"THERAPIST"		"BILINGUAL"
OR		OR
psychologist* therap* counsel?or* counsel?ing clinical adj2 psychologist* counsel?ing adj2 psychologist* psychotherapist* psycho-therapist* analyst* psychoanalyst* psycho-analyst* mental adj2 health adj2 worker mental adj2 health adj2 professional	AND	bilingual* bi-lingual* multilingual* multi-lingual* polylingual* poly-lingual* polyglot* poly-glot* language adj2 switch* code adj2 switch* first adj2 language* second adj2 language* foreign adj2 language* native adj2 language* acquired adj2 language*
MeSH headings		MeSH headings

1.2 Sources of information

psychINFO (1806- June 2010)
Medline (1950- June 2010)
EMBASE (1947-present)
AMED (1985-present)
CINAHL
Cochrane Library
CAB Abstracts (1910-present)
Global Health
Popline
Conference Papers Index
Proquest Dissertations and Theses

Attempts were made to include international health databases (e.g. CAB Abstracts, Global Health and Popline) given the potentially international nature of the subject matter. MeSH heading that were used are identified overleaf for the relevant databases.

1.3 Exclusions:

Non-English language papers
Inaccessible journals

1.4 Date Range Limits:

1806-presnet

Appendix II: Web-based survey

INCLUSION CRITERIA

1. Can you confirm the following?

1.a. I am proficient in more than one language

1.b. I am an accredited therapist or in training for an accredited qualification in the UK

1.c. I am currently engaged in clinical work with clients in the UK

ABOUT YOU

2. Please select your gender

   FEMALE MALE

3. Please select your age group.

   20-29 30-39 40-49 50-59 60-69 70-79 80+

4. Please select a country that best represents your nationality

5. Were you born in the UK?

6. In which year did you arrive in the UK?

ABOUT YOUR EDUCATION

7. How many years of formal education do you have?

8. Please check your highest education level (or the approximate UK equivalent).

Secondary school	Masters
Some college / university	Clinical Doctorate / PhD / MD
Bachelors degree	Professional Training
Some graduate study	Other (PLEASE SPECIFY)

ABOUT YOUR TRAINING AS A THERAPIST

9. In which country did you initially train as a therapist?

10. In which language did you initially train as a therapist?

11. How many years is it since you qualified as a therapist?

ABOUT YOUR CLINICAL WORK

12. Which of the following best represents your current post? Choose one only.

13. Which of the following best represents your current area of work? Choose one only.

14. Which of the following best represents your therapeutic orientation? Choose one only.

ABOUT CULTURES YOU IDENTIFY WITH

15. Please insert the cultures with which you identify. On a scale from zero to ten, please rate the extent to which you identify with each culture.

(For up to six different cultures)

ABOUT YOUR LANGUAGES

16. Please list all the languages you know "'in order of dominance"'

(For up to five languages)

ABOUT YOUR USE OF LANGUAGES

17. Please list your languages in order of acquisition

17a. Please list what percentage of the time you are currently and on average exposed to each language.

17b. When choosing to read a text available in all your languages, in what percentage of cases would you choose to read it in each of your languages?

17.c When choosing a language to speak with a person who is equally fluent in all your languages, what percentage of time would you choose to speak each language?

17d. Have you ever delivered therapy in this language?

17e. What percentage of your work as a therapist has been spent practising in this language?

17f. What percentage of your current therapy workload is in this language?

This is then repeated for the remaining languages (up to five languages)

YOUR LANGUAGE ACQUISITION AND EXPERIENCE

18. For each language please answer the following.

19. How old were you when you

19.a. began acquiring this language

19.b. became fluent in this language

19.c. began reading this language

19.d. became fluent reading this language

20. Please list the number of years and months you spent in each language environment.

20.a. A country where this language is spoken

20.b. A family where this language is spoken

20.c. A school and/or working environment where this language is spoken

21. On a scale from zero to ten, please select your level of proficiency in speaking, understanding, and reading this language.

21.a. Speaking

21.b. Understanding spoken language

21.c. Reading

22. On a scale from zero to ten, please select how much the following factors contributed to your learning this language.

22.a. Interacting with family

22.b. Interacting with friends

22.c. Reading

22.d. Watching TV

22.e. Listening to the radio

22.f. Language tapes/self instruction

23. Please rate to what extent you are currently exposed to this language in the following contexts.

23.a. Interacting with family
23.b. Interacting with friends
23.c. Reading
23.d. Watching TV
23.e. Listening to the radio
23.f. Language tapes/self instruction

24. In your perception, how much of a foreign accent do you have in this language?
25. Please rate how frequently others identify you as a non-native speaker based on your accent in this language.

This is then repeated for the remaining languages (up to five languages)

Please list three challenges you have faced when delivering therapy in a language that is an acquired second language for you, and strategies you have used to overcome them. If this is not applicable to you, please click Continue.
58.a. DESCRIPTION OF CHALLENGE
58.b STRATEGIES USED
This is then repeated three times

A second piece of research will explore the experience of therapy as a therapist who is proficient in more than one language through semi-structured interviews. This will further our understanding of this important phenomenon and the findings will be useful for current and future therapists, both multilingual and monolingual. If you would like to receive some more information about this, please provide your email or telephone number below. By leaving your details, you are not committing to participate, but to receive some further information.

END OF SURVEY

Appendix III: Advert

Are you a therapist or trainee therapist practising in the UK who is proficient in more than one language? If so, please visit the link below to complete an online survey about the languages you speak and practice in. Also, if you are interested in being interviewed about your experiences of being proficient in more than one language and being a therapist, then please contact me or visit the link below:

[INSERT LINK]

David Harvey

psc5dwh@leeds.ac.uk

0113 343 2732

Appendix IV: Approval letter from ethics board

Faculty of Medicine and Health
Research Office

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UNIVERSITY OF LEEDS

Mr David Harvey
Leeds Institute of Health Sciences
University of Leeds
Charles Thakrah Building
101 Clarendon Road
LEEDS LS2 9LJ

18 May 2011

Dear David

Re ref no: **HSLTLM/10/026**
Title: **A survey of bilingual therapists practising in the UK and an interpretative phenomenological analysis of the experience of therapists practising in English as a second language**

I am pleased to inform you that the above research application has been reviewed by the Leeds Institute of Health Sciences and Leeds Institute of Genetics, Health and Therapeutics and Leeds Institute of Molecular Medicine (LIHS/LIGHT/LIMM) joint ethics committee and following receipt of the amendments requested, I can confirm a favourable ethical opinion on the basis described in the application form, protocol and supporting documentation as submitted at date of this letter.

Please notify the committee if you intend to make any amendments to the original research as submitted at date of this approval. This includes recruitment methodology and all changes must be ethically approved prior to implementation. Please contact the Faculty Research Ethics and Governance Administrator for further information (r.e.desouza@leeds.ac.uk)

Ethical approval does not infer you have the right of access to any member of staff or student or documents and the premises of the University of Leeds. Nor does it imply any right of access to the premises of any other organisation, including clinical areas. The committee takes no responsibility for you gaining access to staff, students and/or premises prior to, during or following your research activities.

Please note: You are expected to keep a record of all your approved documentation, as well as documents such as sample consent forms, and other documents relating to the study. This should be kept in your study file, which should be readily available for audit purposes. You will be given a two week notice period if your project is to be audited.

It is our policy to remind everyone that it is your responsibility to comply with Health and Safety, Data Protection and any other legal and/or professional guidelines there may be.

I wish you every success with the project.

Yours sincerely

Laura Stroud

Professor Alastair Hay/Mrs Laura Stroud/Dr David Jayne
Chairs, LIHS/LIGHT/LIMM REC

Appendix V: Information and consent pages from web-based survey

A survey of therapists who are proficient in more than one language practising in the UK.

You have been asked to complete this web-based survey as you are therapist who is proficient in more than one language practicing in the UK. The survey forms part of my doctoral thesis for the Doctorate in Clinical Psychology.

The purpose of the survey is to gather data about bilingual therapists in the UK. Although we are a minority, it is a phenomenon that is increasing. All the data from the survey is anonymised and you will not be identified through the survey. Encryption software is in place to protect the data. To complete the survey will take approximately ten to fifteen minutes. If you speak more than two languages, it will take five minutes more per language. If you have any questions or comments, please contact me on the details below.

Note that once you have clicked on the CONTINUE button at the bottom of each page you cannot return to review or amend that page

Thank you for your time.

David Harvey
Psychologist in clinical training

[email address] [postal address]

A survey of therapists who are proficient in more than one language practising in the UK.

By clicking on Continue you are agreeing that you have read the following statements:
• I have read the previous page and understand the information explaining the above research project.
• I understand that if I have any questions I can contact the researcher whose details are below.
• I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason and without there being any negative consequences.
• I understand that my responses will be kept strictly confidential.
• I give permission for members of the research team to have access to my anonymised responses.

• By clicking on Continue I agree to take part in the above research project.

Appendix VI: Challenges and strategies from web-based survey

CHALLENGE		STRATEGY
MASTER THEME	SUB-THEMES (NUMBER OF RESPONSES) *"Example responses"*	
CHALLENGES OF EXPRESSION FOR THERAPIST	**Not knowing or remembering vocabulary (16)** *"Knowing the correct vocabulary"* *"Not thinking of the appropriate word or expression"*	Use an alternative word or paraphrase Ask the client Read self-help materials in that language Ask to sit in with an interpreter to learn their terminology Provide a description or example
	Not knowing therapy terminology (14) *"Using psychological terminology in a second language"* *"Using 'therapy-talk' with colleagues"*	Read psychological texts in target language Give examples or longer definitions Let the client know
	Not being understood due to accent (9) *"My accent during cognitive assessments"* *"Clients not understanding my accent"*	Speak slower or write things down Ask client to summarise to ensure understanding Encourage clients to ask for clarification if unclear Practice pronunciation of difficult words Record cognitive assessments for inter-rate reliability checks

	Difficulty with written language (8) *"Writing formal letters"* *"Writing therapy letters"*	Re writing clinical notes after session Ask supervisor, colleague or secretary to proof read Use of diagrams in sessions
	Equivalent words not existing (4) *"Finding verbal prompts equivalent to English ones"* *"Not enough terms for emotions in second/third language"*	Try to translate as closely as possible Paraphrase
CHALLENGES OF COMPREHENSION FOR THERAPIST	**Not understanding client accent or dialect (14)** *"Understanding local dialect"* *"Difficulty understanding slight differences in dialect/accents"*	Ask for clarification or repetition Practice listening to the local accent Share this with the client, tell them Over time, become accustomed to accent Use humour to share not fully understanding
	Not understanding slang or colloquialism (10) *"Occasionally not understanding slang words or rare idioms"* *"To understand teenage slang"*	Ask client to clarify Ask colleagues about specific words or phrases Use the context to assume the meaning or make sense
	Not understanding vocabulary used client (7) *"They may be words or expressions I did not understand"* *"Always understanding all words used by clients"*	Ask client for clarification or repetition Use the context to assume the meaning or make sense Use non-verbal information too, such as body language
SLOWER THERAPY SESSIONS (5)	*"Pace of delivery: slower than in native language"* *"Slightly stilted sessions/not as easy to discuss process issues/slightly longer to develop therapeutic relationship"*	Allow sessions to be longer Contract to more sessions

LACK OF MATERIALS AND RESOURCES (7)	*"Unavailability of translated materials"* *"Using psychometrics - problems with translation and explaining concepts"*	Create own Translate materials
UNDERSTANDING OR WORKING WITH CULTURAL DIFFERENCES (11)	*"Don't know past popular culture"* *"Cultural differences e.g. Using first name or using surname"*	Ask for clarification or repetition Ask colleagues about social or cultural references Ask client for explanation Ask client for preference (with use of names etc.) Take issues to supervision Learn and read about history and culture

Appendix VII: Participant information sheet for interviews

An interpretative phenomenological analysis of the experience of therapists practising in English as a second language.

You are being invited to take part in a research project. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please ask if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part. Thank you for reading this.

What is the purpose of the study?
The aim of the study is to explore the experience of therapists practising in English as a second language. By furthering our understanding of this subject we can contribute to the knowledge base of language, self and therapy.

Why have I been chosen?
You have been chosen as a potential participant as you are a therapist who has experience of practising in English as a second language.

Do I have to take part?
It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep (and be asked to sign a consent form). You do not have to give a reason for deciding not to take part.

What do I have to do?
You will take part in an audio-recorded interview talking about your experiences of working as a therapist in English as a second language. The interview will be semi-structured, consist mainly of open questions and last between 60 and 90 minutes. It may take place face-to-face or over the phone. The interviews will then be transcribed and a qualitative analysis will be carried out.

Will I be recorded, and how will the recorded media be used?
Yes, the interview will be audio-recorded. The transcript from the interview will then be analysed. No one outside the project will be allowed access to the original recordings. Material from this transcript will be used in the write up of the project and quotations included – these will all be fully anonymised.

What are the possible disadvantages and risks of taking part?
Taking part in the interviews will mean up 60 to 90 minutes of your time. If any unprofessional or unethical practices were uncovered, this would be discussed with the project supervisors. Any concerns may be discussed with you or in the case of extremely unethical or dangerous practice being discussed, then this may result in reporting it to the Health Professions Council.

What are the possible benefits of taking part?
Taking part in the interview will mean that you get time for reflection on the work you do and your experiences of practising in English as a foreign language. This research will increase our understanding of different language in therapy and the experience of delivering therapy in English as a second language. Therefore, some benefits may not be directly for you, but for therapists of the future who are practising in a second language. It may also help those working with bilingual clients or supervising work where one party is bilingual.

Will my taking part in this project be kept confidential? Where will data be stored?
All the information that we collect about you during the course of the research will be kept strictly confidential. You will not be able to be identified in any reports or publications. Your name and any information that may identify you will be removed and replaced with pseudonyms. Consent forms and the paper document linking pseudonyms and real names will be stored in a locked cabinet on University premises and only members of the research team will have access to it. Any audio data will

also be stored on a secure computer drive of the University of Leeds and removed from the recorder following this transfer. Recordings will be erased after the degree is completed and transcripts will be kept by the research support officers for three years. All electronic and paper files will then be destroyed. If a transcriber is used to type recorded interviews, they will be required to sign a Confidentiality Statement.

What type of information will be sought from me and why is the collection of this information relevant for achieving the research project's objectives?
In the interview you will be asked about your experience of practising as a therapist in English as a second language – this may include opinions, thought, feelings and reactions amongst other things. Gathering this information will help us understand the experience of certain aspects of being a therapist in English as a second language. The findings will contribute to how this experience may be different or similar to native speaking therapists and help us consider and further understand bilingualism in therapy.

Will I be able to withdraw from the project if I change my mind at a later date?
You can withdraw at any time leading up to the interview without giving any reason and without there being any negative consequences for you. If you do not wish to answer any particular question or questions during the interview, you do not have to do so. When the interview is over you will be asked on tape if there is any content of the interview which you feel uncomfortable about being included in analysis. If there is, a discussion will take place between yourself and the interviewer about what will happen in relation to this. Once this has been done and the interview session has finished it will not be possible to withdraw from the study, although all data will be fully anonymised.

What will happen to the results of the research project?
The results of the project will be written up as part of a doctoral thesis as part of a Doctorate in Clinical Psychology for complete ion in the summer of 2012. Certain aspects of the research may be published in an academic journal; however, you will not be identified in any report or publication.

Who is organising and funding the research?
The research forms part of the training contract of the Principal Researcher, which is funded by the Yorkshire and the Humber Strategic Health Authority.

Contact for further information or complaints
If you would like further information, please contact David Harvey on the below details.

Alternatively, please contact:
Dr Carol Martin,
Academic Director,
Faculty of Medicine and Health,
Leeds Institute of Health Sciences,
Charles Thackrah Building**,**
101 Clarendon Road.
Leeds. LS2 9LJ.
Tel: 0113 343 2732.
Email: c.martin@leeds.ac.uk.

If you would like an independent point of information or to make a complaint, please contact:
Clare Skinner,
Faculty Head of Research Support,
Faculty of Medicine and Health Research Office,
Level 10, Worsley Building,
University of Leeds,
Clarendon Road, Leeds, LS2 9NL.
Tel: 0113 343 4897
Email: c.e.skinner@leeds.ac.uk

You will be given a copy of this information sheet for your records. Thank you for your time.

David Harvey 0113 343 2732 psc5dwh@leeds.ac.uk
Psychologist in Clinical Training.
Leeds Institute of Health Sciences
101 Clarendon Road. Leeds. LS2 9LJ

Appendix IIX: Consent form for interviews

An interpretative phenomenological analysis of the experience of therapists practising in English as a second language.

Name of Researcher: David Harvey
Psychologist in Clinical Training.
Leeds Institute of Health Sciences
CHARLES THACKRAH BUILDING.
LS2 9LJ
Telephone: 0113 343 2732
E-mail: psc5dwh@leeds.ac.uk

Initial the box if you agree with the statement to the left

1 I confirm that I have read and understand the information sheet dated 16/05/2011 explaining the above research project and I have had the opportunity to ask questions about the project. ☐

2 I understand that my participation is voluntary and that I am free to withdraw prior to interview without giving any reason and without there being any negative consequences. In addition, should I not wish to answer any particular question or questions, I am free to decline. ☐

3 I understand that my responses will be kept strictly confidential. I give permission for members of the research team to have access to my anonymised responses. I understand that my name will not be linked with the research materials, and I will not be identified or identifiable in the report or reports that result from the research. ☐

4 I agree for the data collected from me via the web-based survey to be identified as mine and understand that this will be fully anonymised in all reports. ☐

Name of participant Date Signature

(*or legal representative*)

Lead researcher Date Signature

To be signed and dated in presence of the participant

Appendix IX: Confidentiality statement for transcribers

Confidentiality statement for transcribers

The British Psychological Society has published a set of guidelines on ethical principles for conducting research. One of these principles concerns maintaining the confidentiality of information obtained from participants during an investigation.

As a transcriber you have access to material obtained from research participants. In concordance with the BPS ethical guidelines, the Ethics Committee of the D.Clin.Psychol course requires that you sign this Confidentiality Statement for every project in which you act as transcriber.

General

1) I understand that the material I am transcribing is confidential.

2) The material transcribed will be discussed with no-one.

3) The identity of research participants will not be divulged.

Transcription procedure

4) Transcription will be conducted in such a way that the confidentiality of the material is maintained.

5) I will ensure that audio-recordings cannot be overheard and that transcripts, or parts of transcripts, are not read by people without official right of access.

6) All materials relating to transcription will be returned to the researcher.

Signed.....**Date**.....

Print name.....

Researcher David Harvey

Project title An interpretative phenomenological analysis of the experience of therapists practising in English as a second language.

Appendix X: Interview schedule

INTERVIEW SCHEDULE: Version 4

MICROPHONE ON

Start recording

Introduce self

Thank you for meeting today

Go through PIS & answer questions

Happy to continue?

Sign consent form.

Tell me (more) about...and then?

Tell me about how that felt.

How come it felt like that?

How did you deal with that?

Any issues / strategies?

How is it different in EASL?

1. Could you tell me a little about how you came to be bilingual?

What languages do you speak?

How did you learn them?

What was the reason for coming to the UK?

2. Could you tell me a little about how you came to be therapist?

What brought you to / interested you in the profession?

Where did you train? In which language(s)?

Have you done training in more than one language?

3. What was it like when you first started delivering therapy in EASL?

What was that session like? Can you tell me more about that session?

Can you tell me a bit more about how that felt? (Emotions, concerns)

What do you think was the reason for feeling like that?

How did you deal with feeling like that?

How was it different doing it in EASL?

4. Can you tell me about a particular case that sticks in your mind from when you first started delivering therapy in EASL?

Can you tell me a little about that client and your work with them?

What's it like?

What happened next? And then?

How did you feel then?

How come you felt like that?

Issues? Strategies?

How do you think it was different doing it in EASL?

I'd like to switch the focus a little now to your current practice.

5. Could you tell me a little about the job you are in now?

Client group? Therapeutic model? Setting? NHS / private?

6. I'd like you to pick a client your <u>currently</u> working with – tell me a little about that case.

Tell me about practising in EASL with that particular client.

What's it like?

How does it feel?

How come you feel...

How do you deal with feeling like that?

Issues & strategies?

How do you think this would have been different if you were working in your native language?

I'd like to focus now on your reactions to clients when practising in EASL.

8. I'd like you to pick a client who provoked a particularly strong reaction from you when working in EASL.

Tell me about the work and your reaction.

What happened? Then what?

How did you feel?

How come you felt like that? Why do you think you reacted to this client that way?

How did you deal with that particularly strong reaction?

What did it you learn about practising in EASL from that reaction / case?

How do you think this would have been different if you were working in your native language?

9. Can you tell me about a client who provoked a more day to day reaction in the last 2 weeks? This may help us talk about a more commonly occurring reaction to clients.

Tell me about the work and your reaction.

What happened? Then what?

How did you feel?

How come you felt like that? Why do you think you reacted to this client that way?

How did you deal with that particularly strong reaction?

What did it you learn about practising in EASL from that reaction / case?

How do you think this would have been different if you were working in your native language?

11. Is there anything else that you think may be important or useful for me to know about?

Any part of the interview that you would like to be excluded?
Any questions?
Give thanks