



UNIVERSITY OF PADOVA

Department of Philosophy, Sociology, Education and Applied Psychology

Master's Degree Course in Clinical, Social and Intercultural Psychology

Final dissertation

**Multilingualism in Therapy: A Qualitative Study on the
Work of Multilingual Psychotherapists**

Supervisor:

Professor Paolo Cottone

Candidate: Giulia Marcon

Student ID number: 2071278

Academic Year 2023/2024

“Da linguagem vem a luz.”

*This author is profoundly thankful
to all the people involved in the
process of research, writing, and
personal discovery.*

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INTRODUCTION

Speaking in another language gives people the opportunity to fill up other parts of their essence through new words, meanings, symbols, and intonations. These provide a new way to see and interact with the world. This thesis was motivated by the multiplicity of ways one can tell one's story, allowing oneself to be understood and to control how and what one says, but also the difficulty that exists of not being understood.

Multilingualism is progressively more relevant in the therapeutic context as more people de-stigmatize mental health and search for professionals who match their linguistic abilities. Globalization and the growing diverse populations lead therapists to encounter patients who exist across multiple cultures and languages. This uniqueness presents several challenges and opportunities for the professional, from understanding how language affects the therapeutic process to how culture affects identity and expressions of trauma.

Studies in many academic fields were driven by the idea of linguistic relativism, also known as the Sapir-Whorf hypothesis, that came around the 1930s. This hypothesis suggests that language does influence thought and not the opposite way (Hussein, 2012). Like Sapir and Whorf, many researchers studied how linguistic habits influenced the perception of reality. Pavlenko (2012) presented the concept of affective processing, proposing that the mother tongue (L1) holds deeper emotional resonance compared to later-learned languages (L2 or LX), which can cause a sense of emotional detachment. This raises the question of how multilingual patients' emotions affect language choice and whether it facilitates or hinders possible therapeutic outcomes.

In therapy, a patient might choose to speak in a language other than their native tongue (LX). This causes emotional distance from painful experiences, allowing them to explore trauma or taboo subjects more comfortably (Verkerk et al., 2024). Inversely, they might choose to speak in their L1 so that a more authentic engagement with their emotions is possible. Understanding this dynamic is crucial for a therapist to provide effective care to a multilingual patient (Cook & Dewaele, 2022; Tannenbaum & Har, 2020).

This thesis explores this complex interaction of multilinguals in therapy by examining how the choices of patients and therapists impact emotional processing, identity, and therapeutic outcomes. By focusing on the work of the psychotherapist, this work seeks to contribute to the knowledge of providing psychological care to a multilingual, no matter the approach used by the professional, accommodating the essential psychic differences of patients who speak more than one language.

This work is divided into four chapters that investigate the complexities of multilingualism in the therapeutic context while examining its implications through a qualitative lens. The first chapter is Theoretical Frameworks, where three subchapters focus on creating the foundation of the role of language. It proposes concepts that are key for multilingual interaction and then explores the complexities from the perspective of the patient and the perspective of the psychotherapist. These subchapters discuss the same focus points of how language affects emotional expression and when language is a challenge for psychotherapists. There is a certain repetition of themes since they consider the same topic from different angles. They discuss the focus points of how language affects emotional expression and when language is a challenge for psychotherapists. The second chapter, Methodology, justifies the choice of qualitative analysis and explains all the steps that were taken to collect, analyze, and discuss the data. The third chapter, Results, presents the findings to demonstrate the emerging topics of the data. The fourth chapter, Networks, focuses on three specific phenomena, each in its subchapter, and discusses them in the context of multilingualism in psychotherapy. Lastly, a conclusion brings a summary and a highlight of this study's relevance and overall achievement.

To contextualize this study within a greater cultural context, it should be noted that most of the participants were mental health providers of the SCUP (Servizi Clinici Universitari Psicologici), the service for psychological support inside the University of Padova. These professionals all work on projects that offer therapy sessions to international students from the University, navigating the complexities of cross-cultural communication. It is to be noted that their professional experiences might have similarities since so many of their patients share the experience of arriving in a new country with a foreign language, sharing the same difficulties with bureaucratic aspects of their stay in Italy. Like many European countries, Italy has had an increase in international mobility which brings on a need for social and cultural awareness of the lives of these immigrants. So much of what came out of interviews referred to the work with international students, however, other participants did have extensive experience in different types of service, which brought balance to the narrative, context, and analysis of their work.

It is important to note that certain concepts are used interchangeably. For clarity of the text, the use of "psychotherapist," "therapist," "psychologist," and "professional" all refer to the person who is listening to the multilingual and providing psychological care. In the first chapter, these words are used based on the article or study being cited. In the other chapters, these words are used with the same meaning to reference the professional who is working with

a multilingual patient. The same goes when referring to the “mother tongue.” Sometimes, it will be read as “native tongue,” “first language,” or even “first-learned language.” All of these have the same meaning: the first language a person ever learned they were just chosen and changed for the fluidity of the text.

Furthermore, another consideration is that through this research, a psychoanalytic lens was applied to explore the dynamics of multilingualism in therapy. The psychoanalytic theory emphasizes the unconscious mind, transference, and early life experiences on psychological functioning. All of these were guides to the data collection and analysis. This perspective is particularly relevant because this approach gives critical attention to the use of language as an indication of deep emotional symbolic meanings, and it contributes to insights into the complex dynamic between language, emotion, and identity.

CHAPTER 1: THEORETICAL FRAMEWORK

1.1 Affective Processing

A fundamental concept of this study is the affective processing used by Aneta Pavlenko in 2012, specifically in the context of bilinguals. The concept has several implications in theories of emotion and cognition, clinical psychology, and even marketing. It challenges the traditional view that cognition functions the same in people who speak different languages, meaning that language would not modulate any emotional engagement or cognitive processing. However, it is known that when some people speak a foreign language, they can feel different or might not be able to express themselves about something specific; their sense of self shifts (Verkerk et al., 2024). To further explain this concept, Pavlenko proposes a comprehensive research review integrating multiple disciplines.

Starting with the idea of embodiment, a term used not only in psychology but also in linguistics to say that cognitive processes are directly related to bodily experiences. Disembodied cognition would then be when someone thinks or speaks in a foreign language. They are provided with a greater emotional distance that influences their decision-making process. This distancing could be called “emotional detachment” or “cognitive distancing.” If a person can reason information differently between languages, there have to be mechanisms in place, so Pavlenko breaks them down by order of language learned and order of implications. Languages learned are: L1 as the native language and LX as any later learned language, or in the case of bilinguals, L2 is the second learned language. Implications are whether it is more advantageous to use one language instead of the other.

Emotion-driven processing is often automatic and unconscious. L1 is favored because it is intertwined with the early formative experience, core memories, and its cultural context, and therefore holds a high emotional charge (Pavlenko, 2012). In contrast, L2 is favored when a controlled and organized setting is possible. Rationalizing and critically analyzing things is easier because emotion is not on the way. The explanation for this is that L2 is likely to have been learned in more sterile places (a classroom, for example) and focused on grammatical points rather than real-life experiences. Failing to connect objects to one’s discrimination of it.

It is not that someone’s emotional trigger only happens in one language, it is that triggers are deeply connected with the words related to that object. For that reason, it is also important to note that even though L2 provides emotional distancing and is preferred in less emotional situations, it can also be used as a tool. As a therapeutic tool, L2 can give the possibility of opening up about a traumatic experience that would be too hurtful to do in a native language.

L2 provides the ability to numb the emotional charge of the memory or cultural prejudices and act as a facilitator to start working, in safety, at the identity and resolution of a problem.

The following paragraphs will present evidence of affective processing in other studies. Cook and Dewaele (2022) demonstrated cases of multilingual refugees living in the United Kingdom who were persecuted in their home country because of their sexuality. In the study, participants were interviewed about their experience in therapy, which happened in their L1, English. The role of language in the therapeutic process is more complex than expected, but it can benefit an articulation of experiences without being retraumatized. Participants in this study provided different relationships with speaking their first and second learned language. From emotional distancing to L2 being a new “safe space,” language allowed them to articulate suppressed aspects of their identity, allowed them to be kinder and less judgmental, and liberated their most authentic sense of self in the therapeutic process.

Similarly, Espin (2013) highlights the implications of the use of taboo words and language in therapy in specific cultures, such as gender and sexuality. As “forbidden” topics keep being inhibited, a foreign language can enable someone to speak of the “unspoken.” She also mentions emotional distancing and the safety and vulnerability that it creates. More specifically, Espin talks of the linguistic shift being used to mediate the weight of cultural judgment and power to navigate the complexities of the identity of the bilingual. Showcasing her clinical experience, she makes the connection between identity and memory. Identity is a very complex concept that is heavily tied to our past and memories, and in the life of someone who has experienced multiple ways of living and multiple places, it can be even more complicated (Espin, 2015). Autobiographical memory provides continuity in maintaining one’s sense of self, but as it is known, memory encoding can be subjective to disruptions, whether they are from outside events, such as migrations or inside events, emotional experiences, and even language signifiers. When speaking about the experience of immigrants, a clash between expectations and experience and the conflicts of cultural change is to be expected, and these challenges are to be addressed with care when it comes to the therapeutic approach.

Another study focused on autobiographical memories in bilingual individuals, but this time in a more cognitive outlook. Schrauf (2002) suggested in a small study that rather than linguistic cues, the bilingual brain was more dominant in memory retrieval with visual imagery and conceptual elements. A highlight of this work is the complex relationship between language and object. The sole act of retrieving a memory can be non-linguistic, but language becomes crucial when memory has to be communicated. It is so because language is the tool

for communication. It is the tool of therapy whether a person chooses to speak in the mother tongue or their second language.

Tonnembaum and Har (2020) were able to address whether the therapeutic process could be as effective in cognitive behavioral therapy (CBT) if the mother tongue was not involved in the process. Highlighting the significance of the native language in cognitive restructuring. In fact, cognitive restructuring was found to be less effective in L2 because the patient may not fully internalize complex thoughts and emotions in that language (Tonnembaum & Har, 2020). This does limit the effectiveness of CBT in a therapeutical context, therefore, including the mother tongue in critical phases of the therapeutical process is advised.

Another study to be mentioned is “RER-LX: A New Scale to Measure Reduced Emotional Resonance in Bilinguals' Later Learnt Language” by Toivo et al. (2022). The study investigated what was qualitatively proposed by Pavlenko (2012) with a quantitative tool. It shows that bilinguals “feel less” while speaking their “second language” in comparison with their mother tongue. The RER-LX is a psychometrically validated tool that measures the reduction in emotional resonance that bilinguals experience when using a language they learned later in life (LX) compared to their first language (L1). The results supported the idea that speaking in LX diminishes emotional resonance, corroborating that the emotional experience of bilinguals is not equally distributed between languages spoken but influenced by the context and order of language acquisition.

So, looking at the variables that were established so far, one would start to think about the other natural differences that may come into play in this complex equation. There are many things to be considered, such as cultural differences, neurological makeup, and upbringing, but for this text, the discussion will continue to focus on personality, the uniqueness of the person, and always in the therapeutical context.

A study by Ibrahim et al. (2020) triangulated the relationship between language, personality, and social interactions. Psycholinguistics and psychodynamics were the approaches used for a more complete picture of this connection. Psycholinguistics analyzes the notion of how language functions in specific cognitive and psychological states and psychodynamics to understand how the unconscious processes influence and are influenced by social interaction. Language was defined as not just a means of communication and expression but as a tool that carries meanings beyond words. Here enters the idea that object relation defines interactions since it is established by early and internalized relationships that represent the self and others. Therefore, the base of someone’s personality is directly related to the formative language – to the words that represent object relation. Further, the paper emphasizes

that language is the means between the ego and the external world (Ibrahimi et al., 2020) and concludes with the position that language can serve as a bridge between the psychological and the social self.

In summary, the affective processing exploration shows a complex, sometimes paradoxical, relationship behind language choice. As a lens that constructs the world, language represents different layers in which individuals navigate their worlds. The articles mentioned some of the complexities of interaction with the multilingual person, and the next subchapter will focus on expanding on this experience, more specifically, inside the therapeutic environment.

1.2 The Multilingual Patient

This subchapter of the theoretical frameworks will look into the complexities of the multilingual patient within the therapeutic setting. It explores aspects of language choices and emotional and cultural influences in the psychological processes. Here, language is seen as the means of communication but also as the patient's vehicle for emotional intricacies.

A pioneer article from 1955 by Krapf described, with five case studies, the dynamic of polyglot patients in psychotherapy. He presents that in psychoanalysis, language serves not just as a medium of expression but also as a vehicle for uncovering unconscious thoughts and desires (Krapf, 1955). Additionally, in Freudian terms, the choice of language can reflect the interactions of the Ego, Id, and especially the Superego, as it embodies moral standards, therefore possibly revealing underlying psychological conflicts.

Krapf (1955) believed that language was a representation of relationships, so the choice of language was linked to their personal experiences inside those relationships, especially the relationship with their parents. With that in mind, the context of language acquisition is important since the context is also driven by psychological distancing or closeness of memories and emotions. Some of his case studies had learned new languages because they migrated to a safer country. Escaping repression generated trauma that was dealt with by using the new language as a way to distance itself from that past reality. Therefore, the unconscious determination of what language is going to be used is based on the context in which it was learned and the level of regulation the person can maintain inside the conversation in such language.

To expand on the context where a language is learned, Brase and Mani (2017) prove wrong the traditional view that L2 is inherently less emotionally engaging than L1 by showing that,

under certain conditions, emotional processing in L2 can approach that of L1. Participants were asked to perform an emotional Stroop task – a cognitive task used to measure how much emotionally charged words interfere with a person's ability to perform the task. They had to complete the reading and then recall words on a computer. The conditions were two: one that incorporated emotional cues and the other without any. The findings show that the emotional depth with which words are learned can affect how those words are processed later (Brase & Mani, 2017).

Moreover, the life of a multilingual person is influenced by many other variables that will later be discussed. Now, the focus will be on understanding the foundational differences in multilingualism and what experience accompanies this path.

As it has been implied so far, multilingualism is not a concept that is universal in experience. For the bilingual, there are at least three differentiations that depend on the context of use, the age in which it was learned, and sociocultural factors. The first is compound bilingualism. Refers to a person who learns the two languages in the same environment, and both of these languages are interconnected when it comes to the representation of things as well as the brain functioning (Baker, 2011; Grosjean, 2010). A good example would be of a child that speaks both the two languages with their parents and interchangeably in the same context. The second is coordinate bilingualism. Refers to a person who learns two languages in distinct environments. This means that the individual uses each language for each context, and therefore, they develop two separate mental representations for each language. An example of this is a person who speaks a language at home with their parents but another language at school or a job, and this often leads to differences in vocabulary or grammar use (Baker, 2011; Hakuta, 1986). The third is subordinate bilingualism. Refers to the process of learning a language based on their first language. Rather than developing an association with the meanings of words in the new language, this individual translates it from the first (Pavlenko, 2014). An example would be when learning a language; the person uses a base language as an intermediate to the new by constantly translating the words and making it harder for the new language to be used independently. To further clarify why this differentiation occurs, other factors need to be explained. Age of acquisition is one of the most defining variables. The earlier a language is learned, the easier is the process of language acquisition. The brain of a child is more flexible and tends to absorb new languages more efficiently than adult brains, this is also referred to as neuroplasticity (Grosjean, 2010) and characterizes early bilingualism, most likely compound bilingualism. In contrast, the later a language is learned, the more critical the process is. Often resulting in coordinate bilingualism, where the second language is processed separately from

the first (Baker, 2011). In regards to the context of learning, it has been established that the environment plays a crucial role in shaping bilingualism. The use of more than one language in a single setting generates compound bilingualism, a frequent use of both languages but in different environments. In the experience of many immigrants, coordinate bilingualism is the tendency (Hakuta, 1986). The frequency of use, as well as the ability to switch languages, can also affect how the languages are mentally represented. An individual who uses their languages equally and frequently are more likely to develop an integration, compound bilingualism, while someone who uses them separately will tend to continue to keep them distinct (Baker, 2011).

In the case of knowing three or more languages, it is called multilingualism. A process even more complex than bilingualism, engaging cognitive, social, and emotional dimensions of the use of language. The whens and hows are similar to what is known for bilingualism attainment. Whether an individual learns all the languages at the same time, as a child or as an adult, they significantly impact how the mind is organized.

Sociocultural factors are a major influence on the experience of multilingualism. The most frequent cases would be in the context of immigration or multicultural communities. Children and adults learn the language, developing distinct types of bilingualism, but also keep their heritage at home. Creating this space where the mother tongue is used inside, or the intimate/personal space of their houses. Nevertheless, in this experience, eventually, one language might become more dominant (Pavlenko, 2014). As for bilingual education, children who are inserted in bilingual education systems are more likely to become compound bilinguals if these languages are used interchangeably in more than one context (Baker, 2011; Grosjean, 2010). Another case would be of cultural identity. The relationship between identity and emotional resonance is frequently expressed by multilinguals as they report feeling differently depending on the language they are speaking. Language choice can bring different aspects of the self to the surface. Compound bilinguals are likely to have more fluidity when expressing their emotions in other languages, whereas coordinate bilinguals might experience a stronger emotional connection to one language, often their first learned language (Pavlenko, 2014; Grosjean, 2010).

Cultural identity is, however, a very complex topic on its own. The relationship of culture and language is characterized by the interaction of dependence and independence (Gal & Irvine, 1995). Language can be both a product of culture and an instrument that shapes and transmits cultural knowledge (Johnson & Giles, 1982). This differentiation is very important to be understood when it comes to the factors that act on the values, practices, and identity of

an individual and on the reflection of societal structures that may exist within a person despite apparent cultural changes (Jessel, 1978).

This relationship is multifaceted. Each plays a crucial role in shaping the other. Language is the vehicle in which culture is communicated. It reflects the perception of the worldview of a community and encloses shared experiences and social norms. In many contexts, cultural differentiation is highly dependent on linguistic characteristics. Language not only forms cultural values but also plays a significant role in differentiating cultures, in some bilingual and multilingual societies, language differences demarcate cultural boundaries.

While culture is transmitted and preserved through languages, language also shapes cultural practices. Some linguistic features may come up or disappear based on cultural norms and values. For example, linguistic practices often reflect the underlying ideologies of a society (Gal & Irvine, 1995). Viewed this way, language can be both dependent on and independent of culture. Linguistic shifts occur as cultural ideologies appear at the same time that they maintain their structural autonomy, persistent even when certain cultural contexts change. This dependence is further seen as how language defines social relationships. Through the Whorfian perspective, language exerts an influence over how individuals perceive reality, and this perception is deeply tied to the cultural frameworks (Jessel, 1978). This mutual relationship becomes clear when looking at phenomena like linguistic relativity, where the language spoken affects how a person perceives and characterizes the world. Furthermore, language has a significant role in cognitive styles and social interaction, as seen after learning a second language. It is noted that linguistic proficiency can be influenced by contexts or cognitive styles that come from cultural factors (Johnson et al., 2000). In collective cultures, for example, language learning emphasizes group communication and shared meaning, whereas in individualistic cultures, language use is more focused on personal expression and autonomy (Johnson et al., 2000). This dynamic bidirectional explains how cultural contexts affect language use but also how language shapes cognitive approaches to communication.

A fundamental view, shared by Perez Foster (1998) in her extensive analytic work, says that language organizes cultural experience because symbolic language itself is embedded in culture and represents the template in which people or groups are organized in their environment. In bilingual individuals, each language holds different emotional and symbolic weight, those might be connections to childhood, trauma, representation of independence and education, and professional identity. And with that, the use of symbolic language differs across languages, creating a variety of emotional and symbolic associations. Affecting how an individual interprets the world, and each language evokes distinct emotional landscapes. In

therapy, the power of symbolic language has to be recognized so that a deeper healing becomes possible. The mother tongue carries cultural connotations and emotional “scripts” that may influence how a patient experiences and expresses emotion. Love, anger, or grief may have different cultural meanings in L1 than in LX. A study by Panicacci and Dewaele (2023) corroborates this idea by saying that if a therapist is able to recognize the significance of the culture of language choice, they can provide care with a more comprehensive understanding of the patient’s emotional range and cultural identity.

Bilingualism is often accompanied by the experience of immigration. Ainslie et al. (2013) talk about the psychoanalytical approach to viewing immigration in a theoretical yet comprehensive article. In a new context, the identity of an immigrant is restructured. Loss and mourning are inherently an experience of the migrant, whether they are physical or immaterial losses. It significantly shapes aspects of the self. “Cultural mourning” (Ainslie, 1998) characterizes a struggle to adapt to their new cultural environment. This is not just a reactive process but an ongoing restructuring of the immigrant’s psyche where it continuously engages in negotiations between holding the past and adapting to the present. This struggle is a mix of the elements of culture, like social norms, rituals (or traditions), and language. Some of these will be explored here. In the psychological organization, language can bridge the past to the future by expressing emotion, connecting with people, and many other crucial aspects of the sense of self. One of the most integral forms of self-identity is when speaking in the mother tongue, the immigrant feels emotional connections to childhood, this can be used as a defense mechanism from the difficulties of the new life and associate themselves with the past. On the contrary, when speaking the language of the new environment, a sense of alienation can emerge as their truer self is not accessible in the new language. Another factor crucial to the structure of the mind of the immigrant is trauma. Trauma experiences can cause fragmentations of the self, and traumatic experiences, whether before, during, or after, can create a dissociated identity. In therapy, this dissociation can appear in the transference or countertransference dynamic, where unresolved trauma is projected within the therapeutic relationship. Furthermore, trauma can also come as an intergenerational transmission as first or second-generation immigrants, adding to the struggle of the organization as it adds layers of cultural identity in a new context (Ainslie et al., 2013).

Lastly, to successfully adapt to the new environment, the article discusses the complex dynamic between original and new cultures through acculturation. This process is challenging and unlocks feelings of loss from the pressure to conform to the new culture or isolation for being alien to their old and new cultural contexts. Failing to process the grief and additional

layers of guilt and isolation can lead to prolonged distress, even manifested as depression or psychosomatic symptoms (Espin, 1993).

The singularity of the beginning of the psychotherapeutic work of an immigrant by Binkowski (2023) explores how immigration forces individuals to confront deep questions about their identity and reinterpret personal history. The analytical encounter is understood as a reenactment of the formative stages of subjectivity, addressing where the cultural and linguistic differences intersect with the individual's psyche, leading to a potential feeling of dislocation. The immigrant's identity is in constant flux, being redefined continuously in response to the environment (Binkowski, 2023). This state of alienation from one's surroundings can lead to a split into an alienation of one's identity. For the experience of the patient in therapy, the psychotherapist should engage in the cultural and linguistic background as a way to respect their individuality in an ethical way that supports their identity – allowing for the patient to pass from being a “speaker” that articulates those experiences, to becoming a “citizen,” someone who participates within their new environment.

Multilingual patients go through unique challenges when it comes to cultural differences in therapy. Knowing the complex relationship between language and culture, language choice in therapy can reveal how patients relate to their cultural heritage and new cultural environments (Verkerk et al., 2024). Choices such as speaking LX because of more frequent life use should be questioned. Language choice reflects the deeper layers of the individual's emotional and cultural struggles. Therefore, the experience in therapy should follow a path of recognition of these nuances and responding to them as a way to strengthen the therapeutic alliance and emotional healing. This restraint in speaking in a certain language indicates a fluid identity that is critical to providing care for multilingual patients, as it suggests that the outcomes of therapy are highly influenced by the language in which it is conducted. The emotional distinction and cultural associations connected to each language are rich yet challenging to work with.

The study of Panicacci and Dewaele (2023) showed the challenges faced when patients discuss emotions in their second language. In this study made with Italians who lived in Anglophone countries, participants reported feeling less genuine when using English. Highlighting the importance of speaking in your mother tongue in therapy, the authors indicate that emotional authenticity and identity are highly influenced by language, and bilinguals often feel more emotionally connected to themselves when speaking in their L1 as it carries stronger emotional resonance and enables greater depth in emotional expression (Panicacci & Dewaele, 2023). This is relevant to the therapeutic context because openness and authenticity are

essential. In contrast, discussing their emotions in LX creates a detachment, a feeling of emotional distance, which inhibits full emotional expression. When patients struggle to access their emotions because of the lack of emotional charge present in LX, Panicacci and Dewaele (2023) suggest that therapists consider allowing and even encouraging patients to switch between languages during sessions. By doing so, therapists can gain insights into the patient's coping mechanisms, emotional regulation, and identity negotiation (Panicacci & Dewaele, 2023). Furthermore, this is even more useful in cases of patients dealing with trauma. As demonstrated in the study, some participants used their LX as a way to distance themselves from the distressing topic and gain more control over their emotional reaction this allows for a gradual approach to the topic without becoming overwhelmed. And eventually, being able to return to their mother tongue and once again articulate those emotions for a therapeutical breakthrough.

This ability to switch languages inside therapy is called code-switching. This term regards the changing of words and also the changing of sentences and phrases and maintaining a whole conversation in another language. Specifically in the topic of trauma, code-switching allows for the treatment to take on a dynamic profile (Verkerk et al., 2023), where the patient can take the emotional distance to protect themselves from re-experiencing such overwhelming emotions, but at the same time, if necessary, being able to access this emotional charge to confront their trauma and fully heal.

Dewaele and Costa (2013) found that patient-initiated code-switching happened more frequently than therapists'. An expected result, but itself indicates that patients lead the language choice during therapy sessions as a tool to manage their emotional expression. This code-switching was closely linked to the emotional tone, with 61% of participants saying they were more likely to change languages when discussing a more emotionally charged topic to intensify or moderate their experience in a particular moment. There is a clear benefit to code-switching, particularly for patients dealing with trauma and shame. The complex landscape of a person who deals with trauma can be eased by the experience of speaking in another language. A distancing from the original experience. The same goes for talking about taboos or culturally constrained topics. A language switch enables a better articulation and expression of those complex emotions/experiences. In the study of Cook and Dewaele (2022), participants were only able to work through their trauma because they spoke in English, and it helped them reconstruct their identity. This idea of identity reconstruction came from redefining and reasserting their sense of self through the medium of a new language. In English, they were able to be compassionate and work on themselves, even with their inner voices. The safety of

English allowed for self-perception and self-acceptance. Identity is not a linear process but one that involves over time in response to context.

Espin (2013) points out in her article "Making Love in English: Language in Psychotherapy with Immigrant Women" that language is deeply connected to one's cultural identity. For many immigrants, a clear link is made with someone's sense of self, cultural heritage, family history, and sense of self. Acculturation is the gradual adaptation to a new culture and involves a negotiation of these identities. Some are intricately connected to the languages spoken by the individual. According to Espin (2013), most immigrants experience feelings of displacement, conflict, and loss of identity. These emotions often appear through the language of their earliest memories and formative experiences. So, when hearing a patient in a language they say is the "most comfortable," the therapist should be able to reason that it is probably something else rather than just a matter of convenience. The choice of language is how they reconnect to their emotions and memories and how they engage in the therapeutic process. Furthermore, Espin (2013) highlights that the language chosen also influences the way multilingual patients engage with their own emotions in the therapeutic environment. Certain emotions, especially those tied to family or culture, are more easily expressed in their native language. That is because memories and emotional states were encoded in the language in which the events occurred, meaning that the native language can open to deeper emotional responses. At the same time, a patient may choose to speak in a second language as a way to emotionally distance themselves from sensitive or painful experiences. The author argues that therapists must be attuned to these linguistic choices, recognizing that language is a dynamic tool through which the patient reconnects to their emotional and psychological past. Moreover, sensitivity to the patient's language preferences is essential, as it enables the therapist to understand how the patient views their history and identity through the bias of a particular language.

As it has been established so far, language plays an important role in the therapeutic process. Children, in particular, tend to be significantly influenced in the way they perceive themselves or express their emotions by the language they use in therapy (Serrani, 2023). The choice of language should be aligned with their sense of belonging. A dissonance could cause feelings of alienation and discomfort, inhibiting an effective expression of their emotions. For instance, a bilingual child who speaks a different language in therapy than that they learned growing up at home might have difficulties accessing memories that were encoded in that language – often the ones about home experiences (Serrani, 2023). This is not just limited to children. Adults have a retrospective perception of the self while using a language that

corresponds to childhood and adolescence, thus bringing emotional responses. Furthermore, the therapeutic relationship is influenced by the linguistic experience, and the choice of language is often chosen because it helps reinterpret the past and reconcile parts of their identity (Serrani, 2023).

Assuming that the work of psychotherapy has to be done in the mother tongue is a presumptuous belief. It is so because it is not always an option, particularly to multilinguals who live in countries where their first language is not spoken. For these patients, the experience in therapy can be challenging. Nevertheless, many multilingual patients demonstrate resilience in the therapeutic setting, finding ways to make the process effective even if the option of speaking their first language is not available. For some, the detachment provided by the use of a second language is beneficial because it allows them to address difficult or painful topics. In fact, speaking about trauma in a non-native language can reduce the emotional charge and making it easier for the patient to discuss the topic without being so overwhelmed (Dewaele & Costa, 2013). Besides all these aspects, the therapeutic space must remain culturally sensitive on the part of the psychotherapist to shelter the experience of the patient no matter how intricately tied to the linguistic experience it might be.

Multilingual patients have a higher level of flexibility, as they have had to adapt to different linguistic and cultural environments (Dewaele & Botes, 2020). In therapy, this could appear as a willingness to explore coping mechanisms or understand emotional regulation. It is also suggested that multilingual patients may have an enhanced ability to adjust to the therapeutic process by confronting unfamiliar and challenging emotions. Social initiative is also a characteristic of the multilingual patient. This is relevant because it shows active engagement in social situations that could contribute to maintaining their work in the therapeutic setting. This is crucial for an effective patient-therapist relationship, with collaboration and actively taking a role in the treatment. Another attribute of the multilingual is their open-mindedness. The ability and willingness to engage in diverse cultural perspectives often leads to a greater understanding of emotional experiences and a broader capacity for empathy. Dewaele and Botes (2020) highlighted that multilinguals have an openness to diverse values and worldviews, which are considered powerful traits in therapy. They approach their issues from more than one cultural perspective, arriving at a more complete comprehension of their experiences and potential solutions. The study of Dewaele and Botes (2020) also noted other less pronounced effects of multilingualism on personality traits. These are emotional stability and cultural empathy. Suggesting that not all multilingual patients exhibit emotional resilience towards diverse cultures, demanding caution of the therapist to not overgeneralize

them based only on linguistic background. Fundamentally, the study underlines the importance of considering a patient's linguistic background as a factor in their personality profile and emotional makeup. For therapists working with multilingual patients, being aware of these potential influences can help tailor therapeutic interventions that line up with the patient's strengths while also addressing any challenges that may arise.

1.3 On the Work of Psychotherapists

Countries all around the world experience an influx of migrant refugees who are not fluent in the dominant language of their new home. This barrier leads to even bigger challenges in the experience of life, especially in health care. Cultural nuances have a direct influence on mental health as it is how individuals express their concerns. The training of psychotherapists, psychologists, and counselors should not be short of multilingual competencies. However, just as found in an Australian study by Tan and Denson (2018), there is a gap in the formal training in the use of a second language as a professional in therapy. Similarly, in the training for multicultural competence, most universities consider it complimentary rather than essential. The findings reinforce the reintegration of these competencies in therapy programs worldwide by redesigning curriculums and rethinking accreditations to apply psychological support in more culturally sensitive ways.

Costa and Dewaele (2013) suggest incorporating multilingualism into psychotherapy training and practice, emphasizing the importance of recognizing the patient's linguistic identity and how it affects therapy. The work of the therapist is enhanced by their own experiences as a language learner in a foreign situation. This shared experience enables an approach that is more supportive of the patient and efficient in the therapeutic process, what the authors call attunement. Attunement would then be contrasted with collusion. This concept refers to the blurring of professional boundaries when similar experiences cloud the judgment, and the therapist starts to work based on assumptions about the patient's narrative. The risk of collusion does not happen only in the case of shared linguistic experience but in the case of any shared background. A key aspect of the care provided by a psychologist is to be aware and clear about their part in the dynamic and their understanding of what is being discussed. It is crucial to question what is an assumption and what was verbalized by the patient. This is where the psychologist maintain their professionalism and initiate their best work. Being able to differentiate what is assumed by you and what is the actual reality to the patient is where the clinical work happens. Understanding what the patient's dynamic forces are, how they are

represented, and how they interfere in their daily life is where a therapist starts to access the real matter of the therapeutic work. The “not knowing” and the imagining in common are characteristics that build strength in the therapeutic process and further relate to the power dynamics in the patient-therapist relationship.

With extensive experience in working with bilinguals, Perez Foster (1996) discusses when patients spontaneously reverted to their native language. Her observations led her to theorize the term Quasitherapy. It refers to the benefit of switching between languages during therapy sessions, accessing deeper emotions, memories, and aspects of their identity that were not readily available in their second language. These could lead to powerful breakthroughs because they come directly from the patient’s inner world, their own psychological material comes to the surface naturally. Moreover, this term recognizes the implications of the sociocultural context in language and identity, taking into consideration power balances, norms, and traditions, as well as other factors that can unconsciously shape emotional expressions in either language.

Curiously, multilingual competencies on the part of the therapist can be a benefit of the care provided to a monolingual patient. A multilingual therapist is expected to be more sensitive and flexible in navigating communication barriers and less biased towards patients (Costa & Dewaele, 2013). The sole ability to express themselves in more than one language increases the grasp of metaphors, emotional connotations, and idiomatic expressions that may happen in therapy. This is a sensitivity skill that brightens the emotional layers of culture that cover the cognitive and emotional processes of any patient. Multilingual therapists hold a higher tolerance for ambiguity in their professional practice. Better handling of these emotional uncertainties allows for a clear and open exploration of the difficulty of expressing without letting the patient feel pressured to provide clear answers immediately (Costa & Dewaele, 2013). Furthermore, they enable openness and flexibility in their interventions, creatively approaching perspectives and solutions. This is especially helpful for a monolingual patient who might be stuck in a specific behavior or thought pattern. The ability to reframe the narrative and offer new perspectives comes from knowing the nuances of identity construction and dynamics of cultural bias, all of which help their patients explore themselves in ways that might not be obvious to monolingual therapists (Dewaele & Costa, 2013).

Tannenbaum and Har (2020) found that many therapists, mainly those practicing the CBT approach, are not fully aware of the importance of the mother tongue in therapy. Proper training and awareness are crucial for therapists to effectively integrate the mother tongue into therapy, especially in multicultural and multilingual contexts (Tannenbaum & Har, 2020). It is

added that ethical guidelines and training programs often focus on cultural competence but do not explicitly address the deep emotional significance of language in therapy. As a result, therapists might miss critical opportunities to optimize treatment by failing to incorporate the mother tongue when appropriate (Tannenbaum & Har, 2020).

To effectively support these patients, therapists need to understand not only the patient's linguistic preferences but also the emotional and cultural implications carried by each language choice. By doing so, they can create a space where multilingual patients feel safe and understood and where therapy can be a transformative experience (Verkerk et al., 2024). It is required that therapists adopt a culturally sensitive and flexible linguistic approach since psychotherapy is the medium for emotional expression, identity formation, and trauma processing. It is essential that the therapist is able to recognize how each language influences emotional expression and identity, as demonstrated by Verkerk et al. (2024). In this study, participants revealed feeling emotionally and personally different depending on the language they were speaking. For example, feeling more authentic and expressive in their L1, which is often connected with upbringing and cultural roots. And having a controlled and detached persona when using their LX. The emotional detachment allowed participants to be able to speak about difficult topics more freely because LX works as a buffer between their emotional experience and their description of them. If seen as a phenomenon, therapists' recognition of this dynamic will better support their multilingual patients in working through their emotional and personal experiences across all their different languages (Verkerk et al., 2024).

Having confidence in working with multilinguals does not come naturally. Costa and Dewaele (2018) described this significant issue by identifying a gap in the training of psychotherapists. Their results indicated that confidence and awareness create comfort in seeing multilingualism as an asset rather than a challenge. Training therapists also showed further importance to cognitive distancing and emotional expression. Therapists improved their authenticity and empathy skills in recognizing the language switches that were connected to changes in the emotional tone.

Continuing on the sensitivity needed when working with multilinguals, it is crucial that the therapist is able to invite the patient into a language switch based on the emotional context of the session. The therapists themselves might feel some discomfort and emotional resonance depending on the language being used. That is why awareness of their own emotional connection affects the therapeutic relationship (Verkerk et al., 2023) and also proper training and supervision to be able to provide care while maintaining their health.

One crucial characteristic of working with multilinguals is recognizing and understanding the multiple “narrative selves” the patients may present. Multilingual patients frequently organize their experiences differently between the languages they speak. These variations reveal a complex narrative structure that can show conflicting parts of the self (Bager-Charleson et al., 2017). Code-switching, as explained earlier, can be a confusing tool, especially for a monolingual psychotherapist. But, as shown by Bager-Charleson et al. (2017), it is also essential. In their study, some therapists encouraged their patients to do so to access different parts of their identity. However, the study also showed that many therapists had a limited understanding of how to effectively handle code-switching. It was suggested that training programs specifically designed to increase awareness of multilingualism should significantly improve the psychotherapist’s capacity to work with a multilingual. Bager-Charleson et al. (2017) also showed that multilingual patients experience shifts in emotional intensity depending on the language they are using. Several participants in their study reported barriers in the narrative, while others indicated an increase in the intensity of narratives. In any case, this poses a need for psychotherapists to enhance their awareness of how language holds emotional meaning for the patient. Attunement to these nuances should facilitate a more empathetic therapeutic process. It was also emphasized that monolingual therapists may unintentionally impose their cultural assumptions onto their patients. Subtly manifesting through wrongful assumptions and difficulty in the patient’s openness and curiosity toward the therapeutic process.

So far, it has been established that the work with multilinguals requires more than just linguistic skills and an understanding of cultural contexts. The same barriers that lead to a collusion also lead to misdiagnosis. Ineffective treatment, as Iudici et al. (2024) note, comes from cultural meanings that are not easy to translate. Developing a sensitivity to language and culture is a core part of the therapeutic process, as it influences the symptoms and engagement of the patient in the therapeutic work. A common miscommunication or misunderstanding comes from working with interpreters. Navigating this complex dynamic, therapists might not fully grasp the patient’s expression and, therefore, unintentionally lay their stereotypes onto the therapeutic interaction. Iudici et al. (2024) also discuss how this might happen through an activation of racial and ethnic stereotypes – from patients who have either a lower verbal skill or if they are emotionally withdrawn. These misunderstandings can strongly impact the treatment in ways that disrupt therapeutic alliance.

Cultural humility is crucial in working with linguistically diverse patients. The assumption that behaviors, communication styles, and emotional expressions are universal

characterizes an ethnocentric view, and therapists must oppose such view. When culturally specific behaviors are interpreted through Western psychiatric models, a critical clinical misjudgment can happen. Thus, disrespectfully misinterpreting the symptom of a person into something that is not. A therapist should remain curious and open to the patient's cultural framework and encourage a more accurate understanding of their experiences and emotional state while avoiding a one-size-fits-all diagnosis. Furthermore, cultural awareness holds a strong position in building trust with multilingual patients. A therapeutic alliance is dependent on understanding the literal meaning of work but also on grasping cultural symbols and social norms that are immersed within their life experience (Iudici et al., 2024). When therapists are attuned to those dimensions, they are more likely to avoid misunderstandings and microaggressions and maintain a better alliance. When working with interpreters, there are some strategies that the psychotherapist can take. Paying attention to the additional layers that the interpreter adds to the therapeutic relationship. Iudici et al. (2024) comment on the inadvertent alteration of meanings of the patient's words by simplifying or building it off their own cultural interpretation. This layer of interaction can disrupt the communication between therapists and patients, therefore leading to misinterpretations that directly affect the treatment outcome. In other words, the presence of an additional person in this process can hinder the delicate balance of trust in therapy, especially if a patient already feels a disconnection with the therapist. A solution to mitigate these challenges is working with interpreters who are trained in mental health contexts. This consistent professional acts as a clear channel that helps understand the psychological narrative while preserving the integrity of the patient.

Iudici et al. (2024) also discuss how the therapist's own biases must be confronted when working with multilinguals. Ethnic and racial stereotypes surface in clinical judgments, particularly when communication barriers are present. For example, patients from minority groups may be more easily diagnosed with disorders like schizophrenia or substance abuse, not because of clinical evidence but because of unconscious biases held by psychotherapists. When the nuances of emotional expression are lost, a higher risk appears of letting the bias take over. And that is precisely why these biases have to be addressed in reflective thinking to examine their assumptions and participation in cultural practices (Iudici et al., 2024). Effective ways to work on one's own bias and provide good quality care are to go under supervision, engage with peer review, and consistently apply reflexivity towards the work. Reflexivity is a key element in maintaining an effective therapeutic relationship, and it enables an environment where the patient feels respected and understood.

Moreover, ethical considerations are integral to ensuring that cultural differences do not hinder the quality of treatment. Iudici et al. (2024) point out the ethical responsibility in promoting multicultural competencies to ensure that biases are constantly being identified and broken down within the context of therapy. If feelings of marginalization are present in a cross-cultural setting, it is the therapist's responsibility to read the power dynamics at play and take the measures so that patients feel safe and heard.

Espin (1993) critiques the androcentric and ethnocentric biases within psychology. She proposes an alternative construction, arguing that cultural and social contexts heavily influence human behavior and emotional processes. Her use of personal anecdotes illustrates how traditional psychological models fail to account for the rich variability in human experience (Espin, 1993). In another article, Espin (1987) discusses the psychological implications of migration for Latina women, particularly focusing on how the migratory process exacerbates gender role conflicts, acculturation stress, and feelings of loss and grief. This focus should be addressed when working with minority groups. Nicolas and Smith (2013) also write about the experience of immigrant women in the United States, but this time Haitian women.

The complex experiences of minority groups are deeply influenced by acculturative stresses and the intersection of gender and cultural expectations. As expected, this unique challenge impacts their mental health and their experience in therapy. Ethnocentrism and cultural insensitivity make these challenges even more exacerbated. Hindering the effects of treatment, psychotherapists who do not fully understand and acknowledge these pressures are at risk of misinterpreting their symptoms as individual psychopathology rather than as responses to broader stresses of migration and acculturation (Espin, 1987). For example, the psychological distress shown by Haitian immigrant women frequently includes depressive symptoms that are linked to the pressures of adjusting to the new environment while trying to maintain connections to their cultural roots (Nicolas & Smith, 2013). Failing to account for these cultural dynamics can lead to misdiagnosis or ineffective treatment strategies. Similarly, Latina immigrants face unique gender role conflicts and expectations because what they experience in the world outside is so intrinsically different from what they experience at home, often resulting in higher psychological distress (Espin, 1987).

The process of adaptation is even more complicated by the presence of unresolved grief. For both Latina and Haitian women, migration often involves leaving behind not only their homes but also critical elements of their cultural identity and support systems. This loss is frequently not recognized in therapy, yet it deeply affects their mental health. Latina immigrants experience a profound sense of mourning for their lost cultural environment, which

can manifest in depression and other emotional disorders if not properly addressed in therapy (Espin, 1987). Haitian women, on the other hand, face added grief from the separation from their children and community, making this adaptation process even more challenging (Nicolas & Smith, 2013).

When working with these populations, a mindful integration of cultural sensitivity as an approach to include an understanding of specific cultural distress can significantly enhance their therapeutic process. This is valid not only for immigrant women but also profoundly facilitates effective engagement in therapy with other emotional worlds, promoting better health for many immigrants and multilinguals to adapt to new environments.

Particularly focused on social justice in multicultural settings, a relevant application would be to add the concept of ethnocultural competencies. Ethno-cultural competence involves cognitive, behavioral, and motivational dimensions that enable effective intercultural communication. This model was defined by Stefanenko and Kupavskaya (2010) and aligns with the critique of ethnocentric monoculturalism by Sue (2004). Both these frameworks highlight the importance of going beyond the cultural norms that shape the current environment, and for psychotherapists, this active engagement with the linguistic and cultural identities of their patients.

A salient point of convergence of these two works is the cognitive dimension in ethnocultural competence and the “invisibility of Whiteness.” Failing to recognize the cultural contexts at play in the life of the multilingual patient is considered a “cultural malpractice” (Sue, 2004) that marginalizes and disrespects the worldview of that patient. Similarly, Stefanenko and Kupavskaya (2010) stress that cultural competence involves more than just recognizing cultural differences it also includes understanding how these differences impact communication. This means realizing that language plays not just the role of a tool of communication but the role of a symbol of identity and belonging (Stefanenko & Kupavskaya, 2010). The lack of this awareness inhibits the possible therapeutic outcomes, especially when a patient is already under pressure to conform to a monocultural and monolingual context that does not represent their reality.

In the behavioral aspect of ethnocultural competence, which involves adapting one’s behavior to different cultural contexts, Sue’s (2004) point on actively breaking down the invisible power structures that can shape therapy adds to the importance of a just therapeutic space. Much of this invisible power imbalance can be seen through nonverbal cues. Picking up on them is a skill to be developed, and therapists should always be attuned to these because it reinforces the deep meanings of cultural diversity beyond what is known by the therapist alone.

Another aspect is the motivation in ethno-cultural competence. Being willing to engage with patients from different cultural contexts is crucial in addressing the disparities in psychological practice (Sue, 2004). Stefanenko and Kupavskaya (2010) argue that therapists must be motivated to interact with patients from diverse cultures but mostly be willing to seek out and engage with other things that will help them offer better care to their patients. This willingness to continuously learn and adapt is essential for therapists working with multilingual. Without this disposition, therapists risk perpetuating the ethnocentric monoculturalism that Sue (2004) so strongly critiques, therefore restricting their ability to provide truly inclusive care.

One more concept that could be added to this discussion is the application of ethnopsychology by Belsiyal (2016). Again, emphasizing the ethnocultural competence of psychotherapists adds practical insights into understanding the patient's worldview and linguistic choices, but mostly their beliefs and social practices as another layer of offering inclusive and respectful treatment. Appreciating spiritual beliefs and traditional remedies is essential in the work of listening, interviewing, and diagnosing a patient with the sensitivity to realize the interaction of all those influences that play in the life of the patient. The same goes for the implementation of interventions that consider the patient's cultural framework. Illness and diseases occur within a cultural and social context (Belsiyal, 2016), and a well-evaluated adaptation of the treatment should not break or disrespect the patient's cultural beliefs.

Similarly, Ainslie et al. (2013) extend this emphasis on cultural competence through the argument of ethnocultural transference in psychoanalytic practice. Cultural, racial, and social backgrounds of both patient and therapist shape their alliance. It is not just a background but an active force in the therapeutic environment. It calls for psychotherapists to have a higher awareness of their own cultural and racial identities and how these can disrupt their perceptions and interactions. It suggests that to navigate a multicultural dyad. Psychotherapists have to thoughtfully reflect on their unconscious prejudices to foster a space for patients that is safe beyond traditional clinical frameworks.

CHAPTER 2: METHODOLOGY

This chapter will examine the choice of methodology in the context of the topic of the research. It aims to reason the alignment between research questions and objectives.

As the topic of this research explores specific interactions of multilingual therapists and patients in a therapeutic setting, a parallel is to be made by recognizing that the researcher and participants were also interacting in a language that is not their first learned language. In the interviews done in this research, the participants' mother tongue was Italian, Portuguese, Georgian, and Spanish, and only one participant was a compound bilingual with English and Italian. The English language was used and should be understood as a tool for communication. A tool for the exploration and clarification of important constructs present in the work of psychotherapists, no matter in what language is used to provide care.

In recognizing English as the vehicle in which communication happened, the focus of this section turns to the fact that this study was designed to collect data through interviews using qualitative methods.

2.1 Methods

The qualitative approach was chosen for this study to explore complex human experiences and social phenomena. Brinkmann (2014) highlights that qualitative methods are particularly suited for examining the subtleties and intricacies of human behavior and interactions, which align with the objectives of this research. The first indication that this is the correct framework came from recognizing the importance of the context. Reducing rich and subjective experiences to rigid variables, as it is quantitative research, could oversimplify and misinterpret the nuances that exist in the therapeutical process. Therefore, the participant's narrative and autonomy in the context were prioritized by the flexibility and adaptability that exist inside this method.

The flexibility of qualitative methods allowed the researcher to adapt the interview questions and approach based on participants' responses. This adaptability was crucial in capturing a comprehensive understanding of the therapists' experiences. For instance, if a participant introduced a new concept or perspective, the interviewer could pursue this topic further, asking additional questions about the emergent theme. This iterative process ensured that the data collected was rich and reflective of the participants' authentic experiences, in other words, "allowing for the researcher's starting point for analyzing the phenomena" (Flick, 2018, p. 8).

Acknowledging the role of the researcher in qualitative research is crucial. Researcher subjectivity can influence various stages of the process, from data collection to interpretation and analysis. To reduce potential biases, reflexivity was consistently practiced. This conduct allowed for a co-construct of knowledge between participant and researcher, but mostly neutrality in the analysis to address any preconceived notions that could affect the interpretation of the data (Guishard et al., 2018).

In this research, a purposeful combination of two approaches was employed. The first was critical analysis. It allowed for a balanced evaluation of the data in its already existing context, enriching this research and thereby deepening the insight of the analytic task itself. This meant that existing knowledge was brought into the process to carefully examine the dynamics existing in the data. The second methodological guide is the grounded theory approach. Grounded theory, coined by Glaser & Strauss (1967), involves generating theory through the systematic gathering and analysis of data. This approach was appropriate for this study as it facilitates the development of a theoretical framework grounded in the therapists' actual experiences and perspectives. Data collection and analysis occurred almost simultaneously and inductively, with initial codes being derived from the data and subsequently refined into more specific or abstract concepts and themes.

Interviews are a fundamental part of the qualitative methods that provide an opportunity for in-depth exploration of participants' experiences, perceptions, and formulations. However, this study chose semi-structured interviews as it balances the need for consistent, comparable data with the flexibility to investigate deeper into participants' unique experiences (Flick, 2018, p. 266). This method allowed the researcher to ask predefined questions while also following up on interesting or unexpected responses, as a result capturing a rich and detailed understanding of each participant's perspective. Tailoring questions to the participant's background and approach while maintaining a comfortable environment, avoiding the feeling of "having to answer correctly," and implementing a possibility to descriptive expression that carries the essence of the answer (Flick, 2018, p. 282).

The topics explored were well-defined during the process of designing this project. The first two big themes investigated were motivated by Costa and Dewaele (2021), whose text orients future research to look at the initiation of language switch and its meaning and management of self-disclosure by therapists who speak multiple languages. The other topics were cultural awareness in listening and supervision.

The interview was designed to take around 1 hour. The longest interview took 1 hour and 32 minutes, the shortest took 35 minutes, and the average length was 53 minutes and 54 seconds.

The questions asked during the interview were divided into two sections, one informational and one narrative gathering. The informational section focused on placing the psychotherapist in their field, understanding their path, and the language acquisition process. The choice to add this section was strategically made to allow for the participant-researcher relationship to establish a solid professional ground while creating a comfortable space to explore the next topics of the interview. Examples of questions were:

- How many years have you been practicing as a psychotherapist?
- Could you briefly describe your journey into becoming a psychotherapist?
- Could you share some insights into how your practice has evolved over the years?

The narrative gathering section was focused on understanding the work of the psychotherapists in sessions with bi- or multilingual patients. The goal was to allow for extensive responses, and participants were encouraged to discourse about topics they thought were relevant to answering their questions. This section was subdivided into Language switch and its significance, Self-disclosure, Formulations, and Supervision. Examples of questions were:

- Can you recall your first experience in offering treatment for a bilingual patient?
- In any of the experiences you have had with bi- or multilingual patients, have they, or you switched languages, used words in another language? Could you attempt to explain why you think that happened?
- Do you feel you could disclose yourself differently when practicing in English or Italian?
- How do you make yourself aware of your patients' point of view?

2.2 Participants

This section aims to enlighten the background and profile of the participants interviewed in this study. All the information revealed here is important for proper comprehension and interpretation of the results. With respect to the right to anonymity, participants' names were changed into practical codes for clarity of the text. Along with protecting their anonymity, some information had to be disconnected from the participant to avoid possible recognition of

colleagues or others who might have known these professionals. For that reason, some demographic data is listed below, whereas others are displayed in Table 1.

All participants in this study are providers of mental health care. They were trained in different approaches and came from diverse backgrounds. As stated above, the reason for making this demographic data available is to grant proper transparency of data and for appropriate interpretation of the results. Later in this text, the discussion of specific cases will contain information regarding the approach or length of experience in the field.

There were a total of 12 participants. Out of those, 8 were psychotherapists, 3 were psychotherapists in training, and 1 was a psychologist. Below is a list of the approaches practiced, ranging from most frequent to least frequent:

- Interactionism,
- Cognitive Behavioral,
- Psychodynamic,
- Gestalt,
- Constructivist,
- Ethno-Systemic,
- Schema, and
- Neuropsychology.

<i>Participant's Code</i>	<i>Work</i>	<i>Years of Practice (in increments of 5)</i>	<i>Length of interview</i>
P01	psychotherapist	less than 5	0:49:50
P02	psychotherapist	10+	00:47:58
P03	psychotherapist	25+	00:49:14
P04	psychotherapist	5+	00:44:44
P05	psychotherapist	30+	00:35:54
P06	psychotherapist in training	less than 5	00:45:35
P07	psychotherapist in training	less than 5	01:02:34
P08	psychologist	5+	01:32:57
P09	psychotherapist	5+	00:53:55
P10	psychotherapist	5+	00:50:58
P11	psychotherapist in training	10+	00:48:11
P12	psychotherapist	15+	00:55:50

Table 1: description of participants.

Other important descriptions are the place of work of these professionals. Some of them offer psychological support through their private practice, institutions like universities or private companies, and through non-profit and governmental organizations. Furthermore, they also work, or have worked, in research, training of personnel, or teaching. Most participants showed a fluctuation between these types of work opportunities until settling into a more steady career. This could indicate a range of multidisciplinary knowledge that is very important in therapy. Within this multidisciplinary profile, it is recognized their work between languages. Whether for a company outside Italy or a project that provides psychotherapy to immigrants, the participants have had the opportunity to shape their approach to the context they have been exposed to, and that is precisely where the interaction with multilinguals happens.

Furthermore, it is important to note that a lot of the content of the interviews was stories of cases of previous or current patients seen by these professionals. It could be considered that these patients were indirect participants. Here, these stories are all treated with respected anonymity, and some have had the gender or key information replaced.

2.3 Procedure

The process for data collection started with seeking ethical approval from the Ethical Committee of Research in Psychology Area 17, which is the responsible entity for ethical approval in all departments of the University of Padova. Once the project was approved, the scheduling of interviews started. Emails were sent to the psychotherapists of the international desk of SCUP (Servizi Clinici Universitari Psicologici) who worked with international students and to other psychologists and psychotherapists who were referred to the researcher. The same email format was used to approach all participants. Only 2 out of 12 participants were recruited through a phone call.

Following the confirmation of interest in participating, a time was scheduled for the interview. 9 out of 12 were conducted through video call. Others happened in either the participant's office or in a quiet public area where the participant felt they could speak freely.

Upon arrival at the set location, the participants were asked to sign an informed consent document that explained the purpose of the research, the administration method, the rights of the participants, and the assurance of anonymity. Participants were also reminded that they could ask for clarification of questions and that there was no expectation concerning the content of their response, meaning that their only concern should be answering the questions to the best of their abilities and in the way they believe it to be true.

Participants were informed when the audio recording of the session started and when it ended. The recording device was the researcher's mobile phone. All recordings were named with an acronym known only by the researcher. The transcribed file was later inserted into MediaSpace, a media platform that allows for video customization that is available for free to all students at the University of Padova to convert audio into a written transcript of the interviews. These transcripts were proofread and organized into a fluid and dynamic nature of communication for analysis in the software chosen for this study, Atlas.ti.

The choice of software was made to bring efficiency and practicality to the process of data analysis. Other than having these characteristics, Atlas.ti has some of its roots in grounded theory, which is consistent with the methodological basis of this research. Atlas.ti allows for an organizational gathering of narrative in a way that allows for the relevant topics to emerge and be studied. To adjust the exploration of the data to better understand how individuals interpret their own experiences.

The procedure inside Atlas.ti is to add a document, highlight the relevant quotes, and tag them with codes that regard meaningful content. The software also offers other tools that are helpful to analysis, like creating notes or memos to start developing profiles or your observations into text from the beginning of the analysis, co-occurrence, which looks into the frequency, pattern, and relationship of two or more codes, graphs, tables and other visual representations of the work.

The data was analyzed using parameters of 40 codes that were created based on the theoretical background of this study and by inductive reasoning as the body of data was collected. The codes were also refined as patterns appeared. Following is a list of the most relevant and frequent codes. Each is accompanied by a short description.

- Affective Processing: based on Pavlenko's (2012) definition. Emotions tied to words differ between languages, with multilingual individuals accessing a broader emotional range and cultural identities. Language in therapy can impact emotional tone, and traumatic memories are linked to the language they occur in. Multilinguals may choose words from different languages based on nuance or richness of expression, with emotions tied to native language words often stronger. This code was chosen based on the significance of the concept to this research.
- Challenging Communication: An instance where communication is difficult due to fluency or cultural differences, but this difficulty does not amount to a barrier. Therapists might overcome these difficulties through a range of professional tools.

- Clinical Situation: Put the quote in the context of the experience faced by the patient-therapist relationship, emphasizing the significance of language and cultural understanding in building effective therapeutic relationships into the dynamic of this practice. It focuses on the impact of language on communication, self-expression, and therapeutic outcomes. Underscores the importance of cultural awareness, empathy, and effective communication in promoting positive therapeutic outcomes in diverse settings. Inspired by the management of the relationship mentioned in Costa and Dewaele's work (2013).
 - Clinical Situation: Collusion
 - Clinical Situation: L1 Emotional Charge
 - Clinical Situation: Linguistic Detachment
 - Clinical Situation: Reflexivity
- Communication Barrier: situations where the language presented a significant obstacle in understanding or progressing with treatment plans.
- Cultural Sensitivity: Inspired by the idea of cultural sensitivity and humility inside the clinical practice as an instrument for a better clinical practice, mentioned in the work of Iudici et al. (2024). It is part of therapists' ethical responsibility. It promotes multicultural competencies and creates a safe, respectful, and conscious space for the multicultural patient.
- Cultural Understanding: To have deep knowledge or experience in a culture different than your own and that is connected to the narrative of the patient.
- Language as Enabler: The impact of language in the therapeutic work with multilingual patients. Emphasizing how language plays a crucial role in helping patients express themselves and aiding therapists in understanding their experiences (Costa & Dewaele, 2018).
 - Language as Enabler: Commentary: refers to a quote that mentions the influence of language in the therapeutic process.
 - Language as Enabler: Negatively: refers to a hindering of the therapeutic process because of another language.
 - Language as Enabler: Positively: refers to the facilitation, empowerment, or even accreditation of therapeutic process because of another language.
- Patient's Experience: In reference to the patient's experience in therapy or life. The review by Altman, Schrauf, and Walters (2013) highlights that immigrant

autobiographical memories are more vivid and emotionally intense when recalled in the native language compared to a second language.

- Quasitherapy: Perez Foster (1996) refers to the way in which essential material may be lost while doing therapy in another language and the benefit of switching between languages during therapy sessions, accessing deeper emotions, memories, and aspects of their identity that were not readily available in their second language. Leading to breakthroughs since whatever psychological material surfaces comes naturally from the patient's inner world.
- Self-Disclosure: When a professional reveals specific information to the patient, personal or not personal, directly or indirectly, even if not entirely true. This code seeks to understand the degree of awareness of what and why is being shared and how it may affect the therapeutic process, like the concept of collusion in Costa and Dewaele (2013).
- Sense of Self: refers to the awareness of how linguistic characteristics change the self in the context of therapy.
 - Sense of Self: for Self-Disclosure
 - Sense of Self: Power Dynamics
 - Sense of Self: Through Another Language
 - Sense of Self: Through L1 Emotional Charge
- Strategy: any instrument, guidance, or choice used with intention and purpose in therapy.
- Supervision: in reference to a space of theoretical, technical, or ethical support for the practice of their safety and professional development.
- Therapeutic Alliance: the relationship between a patient and a mental health professional as the means to effect change in the patient's life. It is a dynamic relationship that is built over time; even though it may include moments of collusion or rupture, the alliance fosters empathy and congruence in the therapeutic work.
- Therapeutic Process: the process that unravels conflicts that can cause suffering to the patient in a conscious, respectful, and consensual manner so that the state of cure can be pursued.
- Therapist Experience: how the life and professional experiences of the therapist work to align with the patient's emotional state, connected to the concept of attunement in Costa and Dewaele (2013).

- Therapist Feelings: In reference to the professional's emotions, thoughts, and feelings in therapy.
- Understanding Limits: A fundamental part of professional life is to fully know one's limitations in the field.
 - Understanding Limits: Does not understand cultural limitation: professionals not knowing they cannot work a particular case.
 - Understanding Limits: Does not understand limitation: professionals not knowing that they do not know about the patient's culture.
 - Understanding Limits: Understands cultural limitation: professionals knowing that they do not know about the patient's culture.
 - Understanding Limits: Understands professional limitation: professionals know they cannot work on a particular case.
 - Understanding Limits: Understands professional limitation in a good way: professionals know they can work on a very particular, hard, or special case.

linked to the therapeutic alliance and, therefore, connected to the ability to provide care to multilingual patients.

The word “people” highlights the relational aspect of the therapeutic work and human interaction. It might show a larger context of the social environment that is touched on in therapy. Which, in the case of multilinguals, is often multicultural as well. The word could also represent how therapists adjust their approach when with patients who have diverse backgrounds and how sometimes it is used to discuss general human experiences.

The word “think” can suggest a focus on the cognitive processes, both from the patient and the therapist during a multilingual therapy session. The cognitive flexibility required by switching language is reflected in the frequent use of this word, and also, the patient-therapist dyad is actively working through language, emotions, and goals. Furthermore, the cognitive load that affects language switches is related to different thinking patterns, this could be a show of the recognition of the pattern of the patient but mostly the thinking pattern of the therapist and how it affects their approach to therapy.

The word “know” is likely to making referencing to knowledge and understanding of the patient’s situation or story and to the constant state of uncertainty that exists in understanding the other in a multilingual context. It also touches on an epistemological point, how the therapists gain and communicate knowledge between languages, taking into consideration their own boundaries. This is an insight into how therapists come to understand the primary issues presented by patients, especially when operating in another language, and how they challenge the limits of not knowing and see the unknowing as an integral part of the therapeutic process.

The word “work” probably refers to the more practical aspects of therapy sessions, and the therapeutical “work” can be done differently in multilingual contexts and to the efforted that is involved in navigating language barriers in the therapeutical work. Also relates to the psychotherapy process where a certain method or approach might produce a different result inside a session and therefore undertaking the effectiveness of such process when a linguistic challenge might be encountered.

The word “say” relates to communication and expression in this setting, where the language choice can affect how something can be said and perceived. It enlightens the active dialogue in therapy sessions, emphasizing that sometimes words do more than convey a single meaning, they express deeper emotions and translate whole experiences. How something is “said” by a multilingual in therapy might be more important than what is being “said.”

The word “maybe” provides a sense of the natural uncertainty of exploring the feelings and thoughts of someone from a complex background, the intricate language switches, and their meanings. It also shows how therapists might deal with ambiguity and justify the way they manage their interventions.

The word “understand” is vital to the work of psychotherapists. It relates to empathy and the therapeutical alliance overall inside their own linguistic nuances that heavily affect the therapeutical experience. To “understand” the other, one must work from their own perspective taking, and in therapy, this work becomes even more complex. The true ability to connect when your meanings and biases are different from the other’s indicates that this work is not an easy skill to learn. It is also curious that the frequency of this word is similar to the frequency of the word “maybe.”

The word “experience” makes reference to the professional experiences and the patient’s life experiences. In multilingual therapy, the word could also mean what each language represents for the therapeutical outcome.

The word “speak” indicates the management of verbal communication between different languages and suggests a reflection of the challenges in navigating such conversations. Here, the relevance of code-switching comes into play. The impact of speaking in different languages strongly impacts the therapeutical dynamics, and it seems that the participants are aware of it.

The word “different” refers to the contrasting characteristics of the languages, cultural backgrounds, and approaches between psychotherapists. The diversity existing inside psychotherapy is frequently contrasted with the diversity of the psychotherapists themselves. This cross-cultural dynamic inside the work frames the possibilities and vulnerability of the care psychotherapists can provide. Therapists must remain sensitive to the “differences” and how they affect themselves and their work.

The word “patient” is self-explanatory, but it is crucial to the discussion of providing the best care possible to the multilingual patient. Holding the central position in how to create a supportive space where they can feel comfortable to express themselves, their identity, and culture in whatever psychological state and language it might be.

The word “really” might accentuate the effort, clarity, and intensity of therapy. It likely shows the attempt to carry something essential when a linguistic barrier is present. The word is an intensifier, and it is probably used to emphasize emotions and meanings.

The word “let” implies facilitation, and in the context of the work of psychotherapists, it is likely inferred to let facilitation of the therapeutic process by allowing the patient to freely

express themselves or the therapist to disclose some aspects of their own identity in therapy, and sometimes in another language. Connecting with self-disclosure, this word could relate to the boundaries of the therapeutic work. What is okay to share, what should not be shared, and how they know how much of their own relationship with a language is “let in” the therapy session.

The word “first” is relevant because it was present in one of the questions of the interview, asking for a narrative of their first experience working with multilinguals. It is seen that both for the patient and the therapist, the expectations of the work have to be managed. So often, the initial experience creates the tone for future interactions. It appears that the frequency of this word is due to the impact of first experiences and the amount of work necessary to fully grasp them.

This word analysis provides insights into the prevalent themes of the multilingual psychotherapy environment. The most prominent words point to the critical role of linguistic processes in the outcomes of therapy. Others emphasize the complexities of the multilingual setting, where not only the patient but the psychotherapist has to navigate cultural and linguistic barriers. And finally, suggesting that the way psychotherapy is carried out matters, revealing that language offers unique opportunities for therapeutic work.

3.2 Co-occurrences

The software Atlas.ti offers a tool for the co-occurrence of themes. This tool is used to identify codes that overlap and the frequency between those. The use of theme analysis is useful because it allows for a description of the corpus of the interviews. How the variables are connected and themes that emerged from the questions. Following is an overview of the most relevant occurrences.

	Language as Enabler: Commentary 62	Language as Enabler: Negatively 14	Language as Enabler: Positively 38
Patient's Experience 129	28	4	15
Patient's Language Proficiency 48	4		4
Patient's Migration 30	9	2	3

Table 2: intersection between three columns, Language as Enabler codes, and three rows, Patient codes. For every intersection is a cell, and each contains numerical values indicating the number of co-occurrences between the codes. The cells are shaded from light green, lower number of co-occurrences, to dark blue, higher number of co-occurrences.

This table showcases the intersections between various patient-related factors and how language serves as an enabler to the experience in multilingual therapy. The data reveals that the patient’s migration experiences and language proficiency play subtle roles in impacting the therapeutic process. While language proficiency does not often appear to be negatively

associated with enabling, it emerges as a positive enabler. Migration, though not always directly connected to negative or positive outcomes, brings out considerable commentary, highlighting the therapist’s attention to the complexities introduced by language in therapy for multilingual migrants. This might be so due to the “unknowing” considerations inside of the clinical practice. This comes from a place of recognizing that the holder of meaning is the patient, and the psychotherapist works towards the “understanding in common.” So, sometimes, a therapist will take a general position rather than defining it as positive or negative, like what is seen here. There is far more commentary on language enabling the treatment process than any proper definition of how it does so. An excerpt of the interview with participant P12 that defines the correlation between a commentary on language as an enabler and a patient’s experience is:

(Q01) “He was used to do it all by himself. He was used to stay hidden. Okay? So in this case, the language was the instrument through which he used to do this? And this was very well marked by the fact that he was here from 20 years. Okay. And he was speaking Italian like a person who came here the other day two days ago.”

In this quote, the psychotherapist explicitly comments on the way language served this patient in therapy and, more broadly, in life. This patient lived in Italy for over 20 years and still could not communicate with most people around him. Within his cultural framework and life experience, he continuously chose not to be part of the Italian community by not speaking the language. This shaped his experience everywhere he went.

	● ◇ Language as Enabler: Commentary Ⓜ 62	● ◇ Language as Enabler: Negatively Ⓜ 14	● ◇ Language as Enabler: Positively Ⓜ 38
● ◇ Clinical Situation: Colusion Ⓜ 29	11	5	1
● ◇ Clinical Situation: L1 Emotional Charge Ⓜ 33	6	2	9
● ◇ Clinical Situation: Linguistic Detachment Ⓜ 66	13	6	14
● ◇ Clinical Situation: Reflexivity Ⓜ 97	26	7	16

Table 3: intersection between three columns, Language as Enabler codes, and four rows, Clinical Situation codes. For every intersection is a cell, and each contains numerical values indicating the number of co-occurrences between the codes. The cells are shaded from light green, lower number of co-occurrences, to dark blue, higher number of co-occurrences.

This table presents the intersections between various clinical situations and the role of language as an enabler in multilingual therapy. The data reveals that reflexivity as a clinical situation is the most frequent correlation to when therapists engage with the impact of language. Curiously, the use of the first language appears to be a significant positive enabler in therapy, enabling a deeper emotional expression. Linguistic detachment offers both challenges and opportunities, as the psychological distance created by using a later learned language can either

create a difficult emotional connection or provide a therapeutic buffer. When asked to recall about the hardest case with a multilingual patient, participant P08 answered:

(Q02) “Because you realize that when you are going in a session with maybe you of course you already know it, but I will tell you. You realize in sessions with foreign students students or whatever people. Since you were both no native speaker because I didn't have native speaker. I had an Irish girl but she came like twice and that's it. It was very quick thing. Since it's not we were all no Native speaker, the effort was in making the other person understand what you were saying both for me and the other person. And they forced both, it forced both to simplify to make all the thought easier. To say. And this process in the language point of view, allowed us also to make the thought easier. So to deconstruct all the pieces and... And realized that it was easier than we thought. Yeah. So maybe but this is a hypothesis. I just one way I lived all this experience. Maybe it's about maybe speaking a different language allows us to to think more before saying stuff. And while thinking to make it easier. Also for ourself. Yeah. Since we tend to create complexity, but it's not what we need sometimes.”

What is curious about this excerpt is the reflexivity the therapist did while she was speaking. It was very interesting to see that she was looking for the answer to how language affects therapeutic work. There is reflexivity in how she performed in session with a native English speaker when she speaks with other non-native English speakers, and finally, how all of these are ways of working with the emotional material in therapy by complicating and simplifying what needs to be said.

	●◇ Language as Enabler: Commentary 62	●◇ Language as Enabler: Negatively 14	●◇ Language as Enabler: Positively 38
●◇ Therapeutic Alliance 106	15	6	17
●◇ Therapeutic Process 116	23	3	16
●◇ Therapist Experience 146	30	8	18
●◇ Therapist Feelings 57	14	6	5

Table 4: intersection between three columns, Language as Enabler codes, and four rows, Therapist codes. For every intersection is a cell, and each contains numerical values indicating the number of co-occurrences between the codes. The cells are shaded from light green, lower number of co-occurrences, to dark blue, higher number of co-occurrences.

This table explores the intersections between key therapeutic factors and the role of language as an enabler to the experience in multilingual therapy. The data shows that language often has a positive impact, particularly in enhancing the therapeutic process and strengthening the alliance between therapist and patient. Nonetheless, therapists' personal experiences reflect the complexity of working in multilingual environments, showing an imbalance between

positive and negative impacts. This suggests that the participants were more likely to speak positively about their experiences, likely due to a desirability bias and therefore favoring their professional skills rather than speaking about their failures and mistakes.

While language can enrich the therapeutic journey, it also requires careful navigation to address both the emotional and practical challenges it introduces. Here is a quote on the commentary of language as an enabler that is embedded in the therapist’s experience from the interview with participant P01:

(Q03) “But since I had this exercise with the second language and following patient in the second language, I was always forced to try to understand better what is, I don't know, “tristesse” for French people because maybe it's not like sadness. I am always trying to go deeper in the meaning of things. Because it changes a lot and I can see that it changes. And sometimes there are words that I don't even know and I need explanation. This is a very, very, very good exercise that I think. It's not only for therapist that follows in different patients from different countries, but for all types of therapists. It’s a practice that we have to exercise and if we are in our own language following patients in our own language, maybe sometimes we forget this... and maybe sometimes we have no chance to exercise this “not knowing filter”, because we assume a take something. I will immediately think about this thing in my own construct.”

In this excerpt, the psychotherapist is speaking on how she works on perceiving the experience of the other and adopting a posture of not knowing. Allowing herself to dive into their meaning-making process and symbolism, and developing that knowledge in common. She explicitly recognizes that by exemplifying the erroneous translation of “tristesse” in French into “sadness” in English.

	● ◇ Cultural Sensitivity ③③ 129	● ◇ Cultural Understanding ③③ 33
● ◇ Therapeutic Alliance ③③ 106	52	10
● ◇ Therapeutic Process ③③ 116	46	7
● ◇ Therapist Experience ③③ 146	59	11
● ◇ Therapist Feelings ③③ 57	20	5

Table 5: intersection between two columns, Culture codes, and four rows, Therapist codes. For every intersection is a cell, and each contains numerical values indicating the number of co-occurrences between the codes. The cells are shaded from light green, lower number of co-occurrences, to dark blue, higher number of co-occurrences.

This table allows the exploration of central stances on cultural knowledge and key factors of the therapist’s work. The frequency of co-occurrences is far higher with cultural sensitivity in relation to cultural understanding. These results allow for a clear understanding that most professionals who work in multilingual settings do not have that much interaction with the culture of the patient. Instead, they work from a standpoint of respect and curiosity towards the unknown. Here is an excerpt of participant P06’s answer to the question about his first experience when working with a multilingual patient:

(Q04) “And also, I realized very quickly how important cultural aspects were differences in sort of cultural approaches because. This couple that I was following their approach was completely different or my Italian clients. But because sort of I come from a bit of a multicultural family, I was able to sort of align to their vision also. Whereas I think if they had been matched to an Italian clinician would have been certain elements that perhaps would have been maybe more problematic or seen as very, very different from Italian culture. Perhaps, bordering on pathological. But I was able to reinscribe it within their culture that I was kind of familiar with. So it was very interesting, very eye opening. It was new for me, so I was quite worried at the start, but it went okay.”

The psychotherapist is Italian. When he mentions being matched with another Italian professional, he means a professional who did not have the multicultural skills he acquired in his personal experiences. And this is precisely why this intersection is relevant. Despite his insecurity at the beginning, he was sensitive enough to treat the multicultural couple and was to be able to treat them.

	● ◊ Challenging Communication 📊 74	● ◊ Communication Barrier 📊 49
● ◊ Language as Enabler: Commentary 📊 62	18	9
● ◊ Language as Enabler: Negatively 📊 14	2	4
● ◊ Language as Enabler: Positively 📊 38	6	3

Table 6: the intersection between two columns, Communication codes, and three rows, Language as Enabler codes. Each intersection is a cell, and each contains numerical values indicating the number of co-occurrences between the codes. The cells are shaded from light green, lower number of co-occurrences, to dark blue, higher number of co-occurrences.

This table examines the dynamics and efficacy of communication. This was chosen to clarify the difference between language fluency and the ability to translate thoughts and emotions to their depth of meaning. As expected, the only case where language did not act as an enabler in the therapeutic process was when there were barriers to communication. Both the

commentary and positive enabling co-occurrences were exactly two times more frequent for challenging communication than for barriers. In the following paragraph is a quote from the interview with participant P10:

(Q05) “That's a good question. When I'm working with the asylum seeker and refugees we have to also consider the fact that in many of the places where they come from psychology is not something known or considered or neither familiar. So first of all, I need to understand how these ‘plates’, we know this space, we are building together could make some sense for them. I cannot start with the idea that I am the psychotherapist and they know what they are they can ask or they can take from me. So it's a process of co-construction of who am I for you, who are you for me, what can we do together? How can we negotiate, meaning that can be healing for you. So I would say that it's a constant trying to clarify, trying to understand, trying to explain me better.”

The psychotherapist broadens the efficacy of her work in psychotherapy by adding the layer of what is professional and the work itself. Even if possible, the translation of the word “psychotherapist” might not have any meaning to someone from a completely different background. Nonetheless, the therapist shows that even in difficult communicative situations, language can be seen positively by creating new meanings for the therapeutic dyad itself.

	●◇ Language as Enabler: Commentary Ⓜ 62	●◇ Language as Enabler: Negatively Ⓜ 14	●◇ Language as Enabler: Positively Ⓜ 38
●◇ Sense of Self: for Self-Disclosure Ⓜ 21	2		3
●◇ Sense of Self: Power Dynamics Ⓜ 39	11	3	7
●◇ Sense of Self: Through Another Language Ⓜ 44	14	3	7
●◇ Sense of Self: Through L1 Emotional Charge Ⓜ 18	5	1	4

Table 7: the intersection between three columns, Language as Enabler codes, and four rows, Sense of Self codes. Each intersection is a cell, and each contains numerical values indicating the number of co-occurrences between the codes. The cells are shaded from light green, lower number of co-occurrences, to dark blue, higher number of co-occurrences.

This table showcases the relationship between the language in which the therapy work happens and its enabling ability and the sense of self of therapists inside the therapeutic dyad. It was considered important to investigate this relationship because it is expected that a person’s identity and or self-esteem could be defined by the language in which they speak, and therefore, displaying this impact in the therapeutic work and how they feel about themselves while working in such language. Since the therapists interviewed were asked about their work in another language, higher results in sense of self through another language are expected. Nevertheless, correlated with the commentary on language as an enabler, it shows that participants were mostly speaking about their patient’s linguistic experience. This indicates an

awareness of the fact that the language spoken does affect their work. The correlations of commentary with power dynamics are also to be mentioned since it also presents an awareness of the fact that the language spoken interferes with the dynamic of power between the dyad. Possibly due to the therapist’s self of self or self-esteem in another language. Following is a quote from the interview with participant P12:

(Q06) “So... the the thing that made the thing hard was that the use that he made of language and the meaning that he gave to language was very different from the one we use. Was very different from the one I I have. Let me say language as a way of exchanging informations in one case and language as an instrument of change in my case. That helps you to open up the theories to open up, and change theories in order to do something different. But the very difficult issue was that this guy didn't want to use language for that. Okay was not was not used to use language in that direction. So just, for example, for the first months, he just said yes or no.”

Here, the psychotherapist explains how the patient corresponded to the treatment in the language they spoke. Almost philosophically, he says that he uses language as a way to cause change in others. This demonstrates his awareness and input on how much influence he could have on the patient. He says that there was not enough communication at all that this patient did not interact or was, in any case, willing to participate in this process.

		● Therapeutic Alliance Ⓜ 106	● Therapeutic Process Ⓜ 116	● Therapist Experience Ⓜ 146	● Therapist Feelings Ⓜ 57
● Sense of Self: for Self-Disclosure Ⓜ 21		9	7	14	7
● Sense of Self: Power Dynamics Ⓜ 39		18	18	23	10
● Sense of Self: Through Another Language Ⓜ 44		14	16	23	11
● Sense of Self: Through L1 Emotional Charge Ⓜ 18		3	5	5	5

Table 8: the intersection between four columns, Therapist codes, and four rows, Sense of Self codes. Each intersection is a cell, and each contains numerical values indicating the number of co-occurrences between the codes. The cells are shaded from light green, lower number of co-occurrences, to dark blue, higher number of co-occurrences.

This table presents the co-occurrences between themes related to the work of the psychotherapist and the sense of self of the psychotherapist. It was crucial to understand how a professional perceives themselves in different languages in the areas of their work because it directly relates to the care they can provide to a patient who also transits between languages. An important element is the high frequency between the sense of self in power dynamics and the sense of self through another language with the therapist’s experience. It underscores precisely the impact of language on their professional identity. This complex dimension can hopefully be clarified with the following excerpt from the interview with participant P04:

(Q07) “Oh, it helps enormously, it helps a lot. I would say that, well, for me, language is kind of the door to the more better space in head and emotionally or mentally. Giving basically more space to these people to express themselves, and it's a huge significance, I would say. Also gives more freedom and gives more I would say confidence as well for me too. But obviously, the thing is that everyone you meet is not speaking the same language as you like in a sense of being a mother tongue. Of course, it must be hard to adjust to every language, but the language that I know, the three, I can definitely say that it's worth it, and it changes the course of the deeper communication. The client goes like, okay, I'm understood not only on this level. I'm understood also on the level of my language, maybe or the way I wanted to express myself like this... gives them more freedom.”

In this quote, the psychotherapist was answering a question on the significance of language switch inside therapy. She strongly highlights the positive influences that being able to express themselves more confidently has on the therapeutic process. The participant also touches on the point of language switch, helping her work when she can switch between them as well. When possible, this language switch enables the therapeutic work to flow efficiently, as power dynamics affect therapeutic alliance and the therapeutic process. In this quote, it is also clear the feeling of the therapist towards the possibility of switching and working on different parts of the self that are attached to different languages. In this next excerpt of the interview with participant P07 talks about another point of view while answering the same question:

(Q08) “That of course, I mean, yeah. We're not trying to understand if, if, it is if it is actually like this, if I'm not actually getting all 100% of their experience because we can not have an answer to this. But sometimes what is real about this topic is the feeling that I'm left with that sometimes I don't think that I got their experiences 100%.”

Here, the psychotherapist is talking about when the patient uses words from a language he does not understand, and he adds the overall idea that even if they share the same language, not all is understood. That is a greater discussion, but in “not knowing,” he keeps working through the dynamic of the dyad to give better care while maintaining his professionalism.

	●◇ Sense of Self: for Self-Disclosure ⊕ 21	●◇ Sense of Self: Power Dynamics ⊕ 39	●◇ Sense of Self: Through Another Language ⊕ 44	●◇ Sense of Self: Through L1 Emotional Charge ⊕ 18
●◇ UL: Does not understand cultural limitation ⊕ 5				
●◇ UL: Does not understand limitation ⊕ 3		1		
●◇ UL: Understands cultural limitation ⊕ 36		9	5	2
●◇ UL: Understands professional limitation in a good way ⊕ 54	4	14	11	4

Table 9: the intersection between four columns, Sense of Self codes, and four rows, Understanding Limits (UL) codes. Each intersection is a cell, and each contains numerical values indicating the number of co-occurrences between the codes. The cells are shaded from light green, lower number of co-occurrences, to dark blue, higher number of co-occurrences.

This table presents the relationship between the awareness of professional limits and abilities and the sense of self of the psychotherapist. It is curious to see the lack of co-occurrences for some of the codes, but these could be explained by these topics not being deeply discussed in the interviews and by a desirability bias as the therapists spoke more positively about themselves. Nevertheless, the following are two quotes about how participants spoke about their limitations and their sense of self concerning it. The first excerpt is from the interview with participant P08:

(Q09) “But always she managed to give me very short answers. Very few elements to work with. And a lot of times she missed the session without without telling me I'm late or I'm not coming. She just didn't show up. So, yes, this was another very strong person. And I didn't manage to create a change there. Okay. And she didn't she decided not to continue the path privately I mean, at some point, of course, maybe I made some mistakes, for sure. I didn't do... maybe I didn't use some tools that I could have maybe to engage her a little more.”

In this quote, it is clear the recognition of the inability to work with a patient. This psychotherapist believed that there were other things to be done to engage this patient in the treatment. In the next excerpt is a more specific limitation taken from the interview with participant P02:

(Q10) “Or there is another situation that I've met her twice, I think. And then there is another colleague that is going on with the therapy with her. And there is a very big point connected to the religion and to the use hijab. So I think these are more or less the situation that come to my mind, which there is something that is cultural...”

When speaking about how he made himself aware of the cultural differences and background, he proceeded to narrate this situation where he referred a patient to another professional because he believed there was someone more capable of caring for the patient. More specifically, the influences of religion and the use of the hijab impacted the power dynamic and the depth of therapeutic alliance, as the symbolism of culture highly influences how therapists and patients see each other.

		● ◇ Cultural Sensitivity ③ 129	● ◇ Cultural Understanding ③ 33
● ◇ Sense of Self: for Self-Disclosure	③ 21	6	1
● ◇ Sense of Self: Power Dynamics	③ 39	18	0
● ◇ Sense of Self: Through Another Language	③ 44	14	3
● ◇ Sense of Self: Through L1 Emotional Charge	③ 18	7	4

Table 10: the intersection between two columns, Culture codes, and four rows, Sense of Self codes. Each intersection is a cell, and each contains numerical values indicating the number of co-occurrences between the codes. The cells are shaded from light green, lower number of co-occurrences, to dark blue, higher number of co-occurrences.

This table showcases two dimensions of the therapy with multilinguals. These intersections highlight how the sense of self interacts with cultural competencies. The relationship of sense of self follows the same patterns as seen before, with far more interaction with sensitivity than understanding. Despite few co-occurrences, the cultural sensitivity intersection with self-disclosure should be a point of attention. When it comes to disclosing personal information, a psychotherapist must be intentional and able to read how this delivery can enhance the therapeutic work. Most of the participants of this research pointed out this idea, but very few talked about how disclosure, especially in another language, can be influenced by their own cultural context. The next paragraph will show a quote from the interview with participant P01, where the professional explores this idea of creating a therapeutic space that includes patients who are from a different background than the therapist's:

(Q11) “Apart from this, I think we should also understand which situation and context we are. Because sometimes if we search so much for the perfect therapy, we risk to be denying to offer the best therapy or the best assistance possible. There is a very important impact when we provide the possible. We can't forget this, yes, it is important to give therapy in a common language. It is important to make yourself clear and to understand the other. It is something really important. We cannot say that it's not. But I don't think that is the only way of creating a therapeutical setting.”

The excerpt illustrates that clear communication does not mean effective therapy. Therapists who work in multilingual contexts must constantly weigh and reflect on how self-disclosure impacts the therapeutic work. Similarly, this asymmetry of the language translation, where things can be left unclear also reflects on the power dynamic inside the therapeutic environment. Cultural misinterpretation happens because therapists work with inappropriate,

biased filters. Putting their cultural expectations on the first plane and disregarding other possible cultural expressions of behavior. Participant P06 said:

(Q12) “And my worry was always to either misinterpret something to link a certain symptom of behavior to a pathological aspect when in reality, if you can textualize it within the culture, it has its reason to be there. And this isn't direct experience, but I know from my colleagues that, for example, working with certain cultures that deal with have certain visions of spirituality and it can be sort of let's say for an Italian clinician or European clinician who doesn't have that knowledge. It can be quite difficult to understand what's going on. So I think there's always a worry to misinterpret things and to not be able to reassure the patient that you are sort of open and not prejudiced towards whatever may come up that's linked to their origins or not. Yes. So I think the real the difficulty is obviously there's going to be a lot of information that's missing that you don't have and that you know that you could make some mistakes or misinterpret something...”

Confronting one's cultural and linguistic limitations is necessary to avoid diagnostic misinterpretations. Ethnopsychology explains this behavior and calls for appropriate cultural training that goes beyond sensitivity to cultural contexts.

To conclude this chapter, it should be reiterated that the work of the psychotherapist in a multilingual context is shaped by the use of language as a tool and recognizing it as a challenge. The analysis of the thematic co-occurrences showed that psychotherapists often perceive their work more positively and, therefore, speak more about the positive effects their work has caused. However, the task of managing multiple languages goes beyond the mere fluency of a language, and it requires understanding the intricacies of how language can influence power dynamics, emotional connection, and the therapeutic outcome in general.

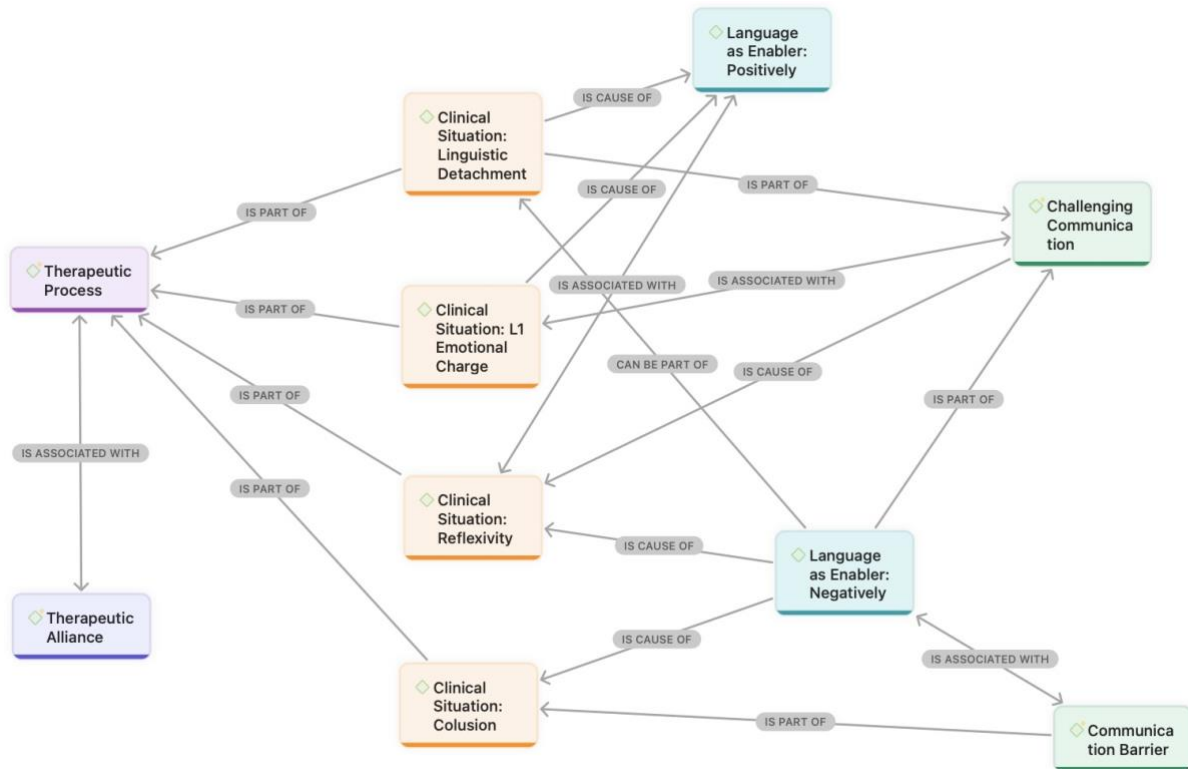
The findings show that reflexivity must always be adopted by psychotherapists, especially when dealing with a multilingual or multicultural patients. The therapeutic stance of “not knowing” is vital to the construction of meaning and fostering correct interpretations when the therapist knows their own limitations. Another crucial aspect of providing proper care is in the therapists' experience. It seems that with experience, professionals are better at recognizing and creating psychological distancing to better the therapeutic alliance.

Ultimately, the work of the psychotherapist in multilingual therapy is not to deal with the linguistic ability of the patient but to embrace the complexities of their linguistic expression

and remain humble and adaptable. By cultivating sensitivity to culture and language, psychotherapists create an inclusive and more effective therapeutic space, one that is respectful of the patient's identity and promotes an authentic therapeutic process.

CHAPTER 4: NETWORKS

4.1 Language Switch and its Significance



Network 1: Language Switch and its Significance is a web that shows the relationship between codes. The network begins with "Therapeutic Process" on the left, branching down to "Therapeutic Alliance" and right into several "Clinical Situation" codes. Each code has a different color based on its theme and is connected to broader themes like "Challenging Communication" and "Language as Enabler." Several lines indicate and name the relationships.

This network shows how language switches impact the whole of the therapeutic work. It has therapeutic alliance and therapeutic process at its core, even if those are displayed on the left end of the network. The relevant instances where multilingualism most influences therapeutic work will be described through the relationship between codes and quotes chosen from the interviews.

On the right end of the network are the two communication codes. Challenges and barriers are both instances when a therapist has to utilize professional tools to adequately carry on their work. A barrier is associated with hindering the therapeutic process precisely because it causes collusion. Participant P01 said:

(Q13) "I think when the patient cannot find the word in the language that we share in common, I think it's hard for them to elaborate the content and the process and the experience that we are discussing there, even if the person knows what they feel... One of the important things of therapy is how we elaborate everything that we feel. And... Maybe this is through language and maybe this is through words. If we don't understand each other in a way, this

could be a limitation for elaborating things which is one of the main objectives of therapy.”

When saying a “limitation for elaborating things”, psychotherapist P01 is saying that therapeutic work is not possible. There are only a couple of options a professional can take at this point. The best would be to direct this patient to someone more appropriate. But with this in mind, a psychotherapist also has to reason if there could be any other possibility to communicate. Sometimes, small gestures make a difference. The following excerpt showed when a psychotherapist with little resources was able to make himself be understood by the patient and eventually understand the patient as well:

(Q14) “I was I was creating some metaphors. I was drawing the metaphors for example, I remember that I use the metaphor of you are putting a seed and then a plant is growing. But you need time. And sometimes it can be windy, sometimes it can be sunny, sometimes it can be rainy. And I remember that this way, Okay. The fact that I, I, I drew the flower in the paper had a really impactful effect. Not so much all the words that we were speaking. But the flower. So with the channel was also this.”

Here, P09 expresses an intense challenge to communicate. The psychotherapist had the help of a translator. However, the use of drawing was more efficient in connecting with the patient than speaking. Communication was only not blocked because he used a universal symbol to display a life passage that depicted the process he was going through. Plants grow everywhere and suffer similar atmospheric conditions, so it was a powerful moment showing he also understood the pressures of the world. It enabled trust between the dyad. Along with this comment, we see that, at that moment, a new layer is built in the framework of the relationship. This is called a clinical situation. The linguistic complexity of the interaction sets the tone of the work that is being done. For example, the excerpt above exists through linguistic detachment. Because the relationship is not happening in the mother tongue of the patient. In fact, it is languageless; it happens through symbols. In this case, it happened in a positive way; it enabled the therapeutic work. But this is not always the case. Sometimes, linguistic detachment can hinder the emotional depth and limit the therapeutic process. Participant P10 has shown that a professional has to work through linguistic meanings to move forward:

(Q15) “Yes, it's very important because if you know what we're talking about, then we can try to find ways to transform it. Otherwise, we are stuck with definitions that are not taking anywhere, no? They are freezing, the possibility

of movement. Whereas, if I find words that can express lead in a more specific more meaningful way for the person. I can also find ways to think about other ways to transform that stuckness.”

This therapist provides the idea that there is a force preventing the work from being done. Something that takes time and creativity, but mostly, it takes a lot of personal reflection to understand the specific impact of language in the therapeutic dyad. Reflexivity is critical in managing the methods of one’s professional approach and continuously understanding how biases interfere with the therapist and the patient’s linguistic choices. Participant P04 explains the reflexivity process inside her own approach. She runs through her thought processes to better assist a patient:

(Q16) “Well, if we are already working and that's the moment that it's hard for the person to express themselves. Firstly, to really check, is it about language or is it something emotional. Because there are many cases that okay. This is not their mother tongue, but something else is happening emotionally speaking, which triggered them or touched them. Maybe to exclude these parts. And if I really notice that it's because of the language barrier. Just be patient and the way I can adjust. I can just offer a little bit of moment sometimes could be I have used this also maybe to give them a little time a minute. Maybe you just stay with it, if you really need more time because sometimes they feel like I have to tell you this very soon because you're waiting for me, you're listening to me and giving them the space like maybe you just take two more minutes, five more minutes you need so that you can put the sentences in your head and stay with it. That helps them a lot. So they don't feel rushed and pressured, and that is the gentle approach. Usually, not only with languages, that's my main, how to say, direction of my therapy also personally speaking, is that being gentle with them. So in terms of that language, I also feel like in that challenging moment, being gentle, being patient that helped me a lot. Even if it was not about language barrier. When they say, ‘it's hard for me to talk right now. It's hard for me to gather the words.’ Just take a minute. Because take a breath. Something is happening maybe that is triggering you. Something is hard for you. You need water. I don't know. It could be many things, right? So just give them time. They don't feel rushed. And that helps me a lot.”

This quote demonstrates the constant questioning of underlying emotional factors. Self-awareness and adaptability on the part of the therapist ensure an impartial position and allow

for a deeper dive into the cause of the struggle itself. When the struggle is in language and its significance, then reflexivity becomes crucial in determining the approaches to permitting the therapeutic process to happen. The same participant adds about the importance of being able to speak the same languages as the patients, or at least being aware of its intricacies in the life of the patient:

(Q17) “Oh, it helps enormously, it helps a lot. I would say that, well, for me, language is kind of the door to the more better space in head and emotionally or mentally. Giving basically more space to these people to express themselves, and it's a huge significance, I would say. Also gives more freedom and gives more I would say confidence as well for me too. But obviously, the thing is that everyone you meet is not speaking the same language as you like in a sense of being a mother tongue. Of course, it must be hard to adjust to every language, but the language that I know, the three, I can definitely say that it's worth it, and it changes the course of the deeper communication. The client goes like, okay, I'm understood not only on this level. I'm understood also on the level of my language, maybe or the way I wanted to express myself like this... gives them more freedom.”

This quote is very important to this research because this participant brought a case that could carry on itself the soul of this study. To wrap up the language switch and its significance section, the *Case of the Trilingual Patient* will be presented. Participant P04 shared that a specific patient with whom they had been working for six months. This patient was having a hard time working through some issues with their family. The therapist knew that this patient spoke many languages. Spoke some languages with specific people in their lives, so the therapist proposed that they switch languages based on the topic of conversation. This therapist is fluent in all three languages of the patient. Initially, there was hesitation. Especially because at the beginning of the therapeutic work, English was the language chosen because the patient felt “more confident” in it and “used it more frequently in their daily life.” As the test of switching languages happened, the patient was able to access the emotional charge of specific memories, relationships, and struggles because they were using the language that relates to them. This therapist reports, “So it was pretty intense, I remember. The language switch was magical.” With a lot of care, sensitivity, confidence, and time, the therapist has facilitated this intricate process that enabled their patient to progress better express themselves.

to me? And this is the central point. So, If I realize that it could be helpful for the person, I'm very happy to do it. Maybe just letting it just very wide way argument. And then if I received some questions, I can get more in depth with the explaining "what happened to me". But the point is to have trust, to trust someone, it's very important to know his her life in the body. Me toward the person, the students. And also the student, my life. Otherwise we are just roles. Generic. Without any personality and a contact."

This quote shows a professional going through their thought process on how self-disclosure could enhance the alliance with a patient. Later, she adds that self-disclosure can also evoke humanness in therapy, reminding the patient that the one who listens to their narrative is someone who also surfs the waves of life and oscillates as the times change. However, when a therapist discloses in a different language, they might face some issues. Obviously, word-to-word translations are known to cause misinterpretations. Many languages contain words that are not translatable. These words carry meaning that cannot be explained by another word, nor even be explained by other sentences. In cases like this, self-disclosure has to be intentionally planned. Not so obviously, a translation of a passage might be hard to convey all its meanings and emotions. Languages carry signifiers that should be considered when a psychotherapist listens to the patient's narratives but also when they self-disclose. Participant P01 explains:

(Q19) "Because in L1 I understand the... the cultural nuances implicit in language. If someone speaks with this accent, I may know the social class that this person comes from. I am biased the language because we have many social representations for some symbols. If a person speaks with some accent, I know that she comes from a region or that she comes from a social class or we have a lot of lenses that will bias. When I am self disclosure in L1, I may use the bias to connect better. Maybe I can adapt my language to arrive to those patients in a better way."

By adapting her language, the therapist uses the language as a tool to achieve a particular emotional or cognitive effect. With that being said, therapists might also be more keen to disclose things in their second language because they are also distanced from their emotional charge, and that is a way to enhance their approach in a controlled way. The same participant reflects on this stance:

(Q20) "Instead. On the other hand, in L2, since I don't have this cultural background. I was not born there. I lived there for four years. Even if I have a

very, very good level of L2, there are some symbolic representations that we don't have that we will never have. It would demand time there. I think I am more universal in L2, I am more pragmatic. I do less biased. I'm less biased by them and I am less biased with myself. So, like, in L1, I think I can adapt the person that I am with and in L2 I am more universal. More ordinary.”

Constantly reflecting on how a language affects their work is extremely important, it is part of the therapist's formation as well. Following is a quote from the interview with participant P06:

(Q21) “Of course, I work with children also, so that's a completely different aspect. It happens that children often ask about your personal life and how old you are and if you have children. So, obviously, I feel more comfortable sharing with them. And that's a different context. But I've noticed that when working with clients that come from yes, an anglophone country moving to Italy, when they realize that I'm bilingual and that I have sort of both elements of the culture, they become very curious about my personal history and how come I'm in Italy and I speak at Italian, but I also I'm native English. So it happened that they asked me questions, and at times because of my approach, that makes me feel quite uneasy. And on the other hand, I recognize some of the struggles that they have in sort of trying to integrate the two cultures because it was part of my life growing up, having sort of English parents in Italian context.”

In this excerpt, the therapist reflects on how her personal story allows her to work in this bilingual context and how the work with a particular patient can change the reasons and ways she discloses information. This excerpt shows all the sense of self subcodes for self-disclosure, through another language, through mother tongue, and for power dynamics. This experience of development enhances her professional experience and shapes her interaction with patients.

However, not all professionals know how the language affects their disclosure. Several participants of this research assumed that they could provide the same care, and interact the same way with all their patients. Language was not a barrier in any sense. This was a negative aspect showing a lack of awareness. Participant P05 was asked about the differences in disclosing in other languages, when they said there was no differences they added:

(Q22) “Why should there be. Let's say that Spanish and Italian are very similar. If it were in English which has very few words for emotions, maybe it would be more difficult. But Spanish has the same, indeed, it has the same words for

emotions that Italian has, so I don't I don't I don't see why there should be a difference. It's so they are so similar the two languages.”

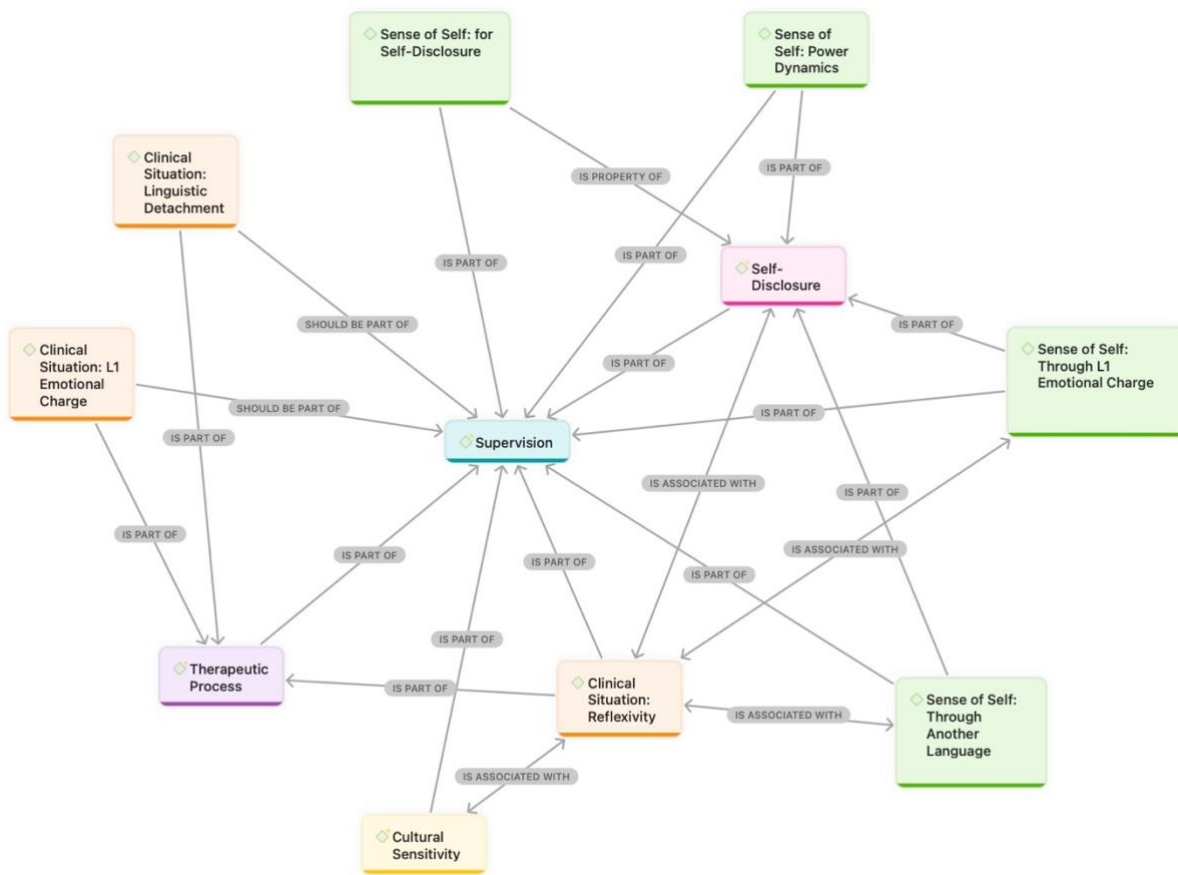
This participant speaks as if all the symbology and meanings of words transfer through the languages she speaks because they are Latin language. They have the same origin and are very similar. The “easy” aspect of translating between similar languages is recognized, but it does not mean that the meaning a word carries is the same between the two languages. An adjective translated from Italian to Spanish can be used grammatically correct but might be incorrectly used because of the social meaning and the context of the phrase. Plus, the professional fails to recognize that Spanish is a language used in other countries. When confronted with this idea they responded by saying that these were not meaningful differences to hinder the therapeutic process and with a mere explanation of meanings they could carry on a therapy session.

Another example of a psychotherapist who did not take self-disclosure in a second language so seriously is in the following excerpt of the interview with P10:

(Q23) “Was a girl from originally from US, but with the Chinese background. She was... So when I started, my worry mainly was okay, she's mother language in English and I'm not will I be able to be understood? No. Because I know that I can I can understand everything. But to speak and to... I mean... hold the conversation in English. Okay. With that is regarding personal things where there is a lot of risk of misunderstandings, not so that was my main worry at the beginning.”

This quote can be somewhat complex to understand what the psychotherapist was trying to say. What she meant was that initially, the idea of working with an English native speaker when English is her second language caused her worry, but eventually, she did not see any problem with it. She adds that her difficulty with English would be to hold a personal conversation, but since that is not the case with her work, she was fine. It should be questioned that if someone cannot hold such conversations in a second language, how can they be sure of the way they disclosure is controlled and intentional like they say it must be?

4.3 Supervision



Network 3: is a web that shows the "Supervision" code at the center, connected to various codes like "Sense of Self for Self-Disclosure," "Clinical Situation," and "Therapeutic Process." Around it, the codes branch out into other related concepts. Each is colored to differentiate them based on the theme. Several lines indicate and name their relationships.

Supervision is a key part of the clinical therapeutic context. It is part of becoming a psychotherapist and a highly recommended practice as it acts as a support mechanism for therapists. It encompasses professional guidance, ethical practice, and the development of cultural competencies, among other things. Even though this practice is more common at the beginning of the professional's career, few participants explicitly brought the topic/influence of language to supervision. Most of them said that if they brought a case of a multilingual to supervision, it was not because of the language but the case in itself. The next quote was taken from the interview with participant P04 and mentioned the *Case of the Trilingual Patient*:

(Q24) "Yeah. I brought for example, the case. And with the three different languages, I brought this to supervision. But the main topic is not of the difficulty with the language. It's more like what is connected to the topics that are connected to that I feel stuck. Yeah. But not the way of it's hard to communicate or not specifically with the languages. Maybe what topics are connected to the different languages, emotions, or situations. But I haven't really

discussed with my supervisor the aspect. Language switch or language change. Okay.”

It was clear that some psychotherapists believed because they had mastered a language, then it was not a topic to be discussed in supervision. The main belief was that it was not language hindering the therapeutic process but other things that were simply being said in a different language. Some also mentioned that their reason for bringing the case to supervision could've been because of how to handle cultural differences. The underlying theme was that language is too tied to other factors for it to be the main point of attention in a case. Even though most of the participants of this research appreciated and valued the work in other languages, they still did not recognize that the language they spoke changed their approach and, therefore, the care they provided. It is important to note that this research recognizes that the quality of the work of any professional is not based on their interaction with a language, but it is clear that those who provide more successful care in a second language have a special sensitivity to the influences language causes. Participant P06 is someone who recognizes it and actively brought this awareness to her work:

(Q25) “So there's a particular let's say the service where I work with children and parents is a service where we work as team. So I would have parents for the kids and another colleague and everything is always discussed as a team. So I felt that the aspect of multilingualism and multiculturalism, in that particular group because it's not an international service. I felt like my colleagues weren't fully aware of those aspects. So I felt like I had in the supervisions and in the interventions. I had to sort of highlight and bring attention to that to the cultural aspect and to the added difficulties that, for example, this family was having in adapting to a completely new environment and language and everything because my Italian colleagues or my Italian supervisors perhaps didn't consider all of those aspects because they're used to just working with Italian So, it would be something that I would bring as an aspect in my supervision. Yes.”

P06 knows from her personal experiences that language and culture have to be considered when offering treatment to multilingual patients. And has seen firsthand how bilingual therapy can benefit patients in terms of expressing themselves and feeling cared for.

Other than making sure to deliver good care to their patients, another reason to bring language aspects into supervision is the fact that the professional has a hard time reasoning these cases in other languages. Participant P07 brings up precisely this argument:

(Q26) “And I have to do this because it is a freaking mess. In the moment, for example, that we do intervention or supervision in my class in psychotherapy school, and I have to talk about a case or a person that I I've seen in English. It's a total disaster to bring it in Italian. It's very difficult. Yeah, it's tiring and I'm consuming.”

How can a professional work through a case, if necessary, if they cannot talk about it with their supervisors? This difficulty could reflect some aspects of the care provided. If a professional is not able to transition between languages outside therapy, can they be sure they are providing the same level of care between the languages? If a professional is not able to work through a case, things like sense of self and clinical situation could be way out of their radar or even out of their ability to change it.

CONCLUSION

This thesis explored the topic of multilingualism in therapy. It focused on how language affects several phenomena inside the therapeutic context. The investigations of the dynamics of language switch and emotional engagement allow this study to clarify how multilingual therapists navigate the linguistic challenges they might face. The main goal was to investigate how therapists can provide better care to their multilingual patients by attuning to their cultural context and linguistic preferences. This study answered its motivation question by learning how therapists interact and formulate their interventions with multilingual patients.

Cultural diversity, just like language and emotional expression, is a fundamental aspect that shapes these therapeutic interactions, as multilingual patients bring with them rich cultural frameworks. These frameworks influence not only how patients experience and express emotions but also how they connect to their identities within therapy. By acknowledging and actively engaging with these cultural dimensions, therapists can deepen their understanding and improve the therapeutic process (Espin, 2013; Panicacci & Dewaele, 2023). This engagement is more than just recognizing language differences, it extends into appreciating the cultural values and emotional nuances that are tied to the patient's linguistic background (Pavlenko, 2012; Verkerk et al., 2024).

Besides, cultural diversity intersects with multiculturalism by making the therapeutic space one that embraces inclusivity. It strengthens the therapeutic alliance and enables therapists to provide more tailored care that respects both the emotional and cultural needs of the patient (Costa & Dewaele, 2013; Iudici et al., 2024). With this in mind, three main takeaways from the analysis are presented next.

The first is from what was learned by understanding language significance and self-disclosure. How a psychotherapist interacts with a multilingual patient is heavily influenced by their language. Psychotherapists should always be aware of their linguistic influence in their formulations. The *Case of the Trilingual Patient* showed that reflexivity throughout the therapeutic process is always important, so much so that self-disclosure was affected by all three languages. In this case, the psychotherapist was intentional about meaning-making and constantly revised their approach to match what was best for that patient, or as noted by Verkerk et al. (2024), the professional had a good linguistic attunement. Other participants were not always as aware of how they disclosed, and this study suggests that professionals should always be aware of how their linguistic habits affect their disclosure.

The other takeaway came from the knowledge of language significance and supervision. Professionals can be wrong about their formulations and meanings.

Psychotherapists should be able to bring these topics to their supervision and should, more frequently, share their experiences with a trusted supervisor. Language and its impact on the formulation process hasn't been seen as something that needs support from other professionals. Yet, when a therapist is constantly subject to their own linguistic and cultural bias, certainty about their influence on the therapeutic process of their patient becomes challenging.

This is where an ethnocultural approach is important, as it encourages therapists to actively acknowledge the influence of their cultural framework on the therapeutic process. Instead of suppressing or ignoring these biases, psychotherapists should integrate this awareness into their practice. By doing so, a more inclusive, open environment where patients feel freer to express themselves without feeling confined to or judged by the cultural norms and values of the therapist is created. Furthermore, psychotherapists should never impose their interpretations based on their cultural background but should remain flexible and attentive to the patient's unique worldview and identity. This approach nurtures a therapeutic space that is attuned to the patient's needs, promoting a deeper understanding and a more meaningful therapeutic alliance.

In addressing the broader implications of psychotherapy in multicultural contexts, ethnopsychology offers the framework for this inclusive and open space. Not only advocates for linguistic attunement but emphasizes the critical search to understanding the cultural identities that influence patient experiences. As discussed, a lack of cultural competence can lead to diagnostic misinterpretations or cultural malpractice, reinforcing the need for therapists to apply ethnocultural awareness in their practice. This would enable them to recognize the symbolic weight of a patient's linguistic choices, as well as the larger cultural context in which their psychological symptoms manifest.

Incorporating ethnopsychology aligns psychotherapy with culturally sensitive treatment practices. By acknowledging and integrating patients' spiritual beliefs, social practices, and worldviews, psychotherapists can move beyond traditional Western frameworks of care. The application of the ethnopsychological approach ensures that treatment does not just address the mental health of multilingual patients through their symptoms but addresses it in their unique cultural identities.

The final takeaway builds on self-disclosure and supervision but with a shift in the focus from the psychotherapist to the patient. While the earlier discussion emphasized the therapist's awareness and responsibility, this point highlights the importance of applying that knowledge in practice. It is not enough for the psychotherapist to simply recognize the significance of language or cultural biases; they must also assess and adjust their approach in real-time. This

means continuously evaluating when and how to adapt their interactions to suit the individual needs of the patient better. Ultimately, it is the therapist's responsibility to ensure that their approach remains flexible and responsive, fostering a therapeutic environment that supports the patient's growth and well-being.

It was also learned from this study that more questions need to be answered. Since a therapist needs to be aware of their biases and their interaction so that it does not bleed into the therapeutic work of their patient, we need to know more about the personal path and self-knowledge of these professionals. This offers deeper, more philosophical reflections about their motivations and authenticity – questions that might help improve the quality of the care they provide. It may also be useful to examine how a therapist's personal growth and experiences, beyond their formal professional training, shape their approach. Investigating how this self-awareness generates greater confidence in their work is another direction of research that is worth exploring. Bringing awareness and knowledge to the sensitivity of language since, as said by Costa and Dewaele (2018), language is easily overlooked.

The corpus of data collected in this study is extensive enough and could be further analyzed to search for these answers and possibly others. It is clear that this topic needs more attention. There are other areas of interaction and care for multilingual patients that deserve to be clarified. More studies on specific linguistic challenges and general ways of how to better support multilingual and multicultural persons should continue to be the focus of psychotherapists nowadays. Exploring specific triggers for code-switching during therapy sessions and its effect on therapeutic outcomes could further explain how language use influences patient care. For example, interviewing patients to compare their perspectives with this data on how language switches during therapy affect therapy outcomes can offer deeper insight into how such practices can either better or hinder therapeutic progress.

Finally, we go back to the affective processing to reinstate the level of influence language has in the work of psychotherapists. The complex dynamic of emotional charge and emotional distancing can be seen between two languages and be used intentionally. There were narratives of psychotherapists who were able to do so and enhance their alliance but also simply facilitate the therapeutic process for their patients. We also go back to the multilingual competencies by Costa and Dewaele (2013) and the cultural humility by Iudici et al. (2024). Some professionals are inadequately trained to address linguistic complexities, and failing to recognize cultural and linguistic significances can lead to misunderstandings, misdiagnosis, or even ineffective treatment. Acknowledging these difficulties and lack of training a professional can start to create a more inclusive and supportive therapeutic environment.

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List of Networks

Network 1: Language Switch and its Significance is a web that shows the relationship between codes. The network begins with "Therapeutic Process" on the left, branching down to "Therapeutic Alliance" and right into several "Clinical Situation" codes. Each code has a different color based on its theme and is connected to broader themes like "Challenging Communication" and "Language as Enabler." Several lines indicate and name the relationships.54

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