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# Multilingualism and psychotherapy: exploring multilingual clients' experiences of language practices in psychotherapy[1]

Louise Rolland, Jean-Marc Dewaele & Beverley Costa

Birkbeck, University of London

## Abstract

This study investigates bi- and multilingual clients' self-reported language practices in counselling and psychotherapy. Quantitative and qualitative data were collected through an international web survey inviting adults who had experienced one-to-one therapy to describe their experiences. Analysis of responses by 109 multilingual clients revealed that clients did not always have an opportunity to discuss their multilingualism with therapists, and for some this inhibited their language switching. Others were assertive in their language choices, or benefited from working with a therapist who was either bilingual or skilled at creating an inclusive linguistic environment. Very few reported two main therapy languages, while nearly two thirds of participants reported short code-switches. These happened occasionally within sessions and were typically linked to difficulties in translation, expressing emotion, accessing memories or quotation. Over a third of respondents used a second or additional language as their main therapy language, with nearly half of this group reporting that they never switched to their first language in sessions, despite some using it daily for inner speech. The implications for therapy and further research are discussed, including the role of the therapist in inviting the client's multiple languages into the therapeutic frame.

**Keywords**: multilingualism; psychotherapy; code-switching; translation; memory; emotion

## Introduction

Nancy Huston, a Canadian expatriate in France, observes with a sense of wonderment that she tells different stories in her different languages:

> Le plus grand vertige, en fait, s'empare de moi au moment où, ayant traduit un de mes propres textes – dans un sens ou dans l'autre – je me rends compte, ébahie : *jamais je n'aurais écrit cela dans l'autre langue !*

> ('I am overcome by vertigo, in fact, when, having translated one of my own texts – in one direction or the other – I realise, astonished: *I would never have written this in the other language !*')[2] (1999, p.52).

Indeed bilinguals may present different facets of their identity or 'selves' according to their language choices (Dewaele, 2016; Koven, 1998; Pavlenko, 2005, 2006). Since bi- and multilinguals have more than one language available to them, they make choices in their interactions with others. These are influenced by their personal

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[2] Author's translation

preferences and negotiated within the social context, however language switches can also arise spontaneously due to the topic being discussed, or emotions aroused.

Therapists have different levels of awareness with regard to bilinguals' language practices and their potential significance (Costa & Dewaele, 2012). There is no professional consensus as to whether therapy in a first language or bilingual therapy are preferable to therapy in a later learned language. Experienced bilingual therapists recommend that, at the very least, language switches are attended to and, where appropriate, facilitated (Costa, 2010; Pérez Foster, 1998).

This study aims to build on Dewaele and Costa's study (2013) of clients' views on language practices in therapy by firstly examining how clients use their language repertoire in therapy, and in what situations, and secondly how therapists' behaviours contribute to enabling or disabling clients' linguistic choices. We focus on self-reported language practices of bi- and multilinguals in one-to-one counselling or psychotherapy sessions – a highly personal environment, in which clients are invited to share their innermost thoughts and feelings. Without access to former clients engaged in research with a therapeutic service, we appealed to the general public and hence the participants are a self-selected group, not representative of the general population. Given its innovative line of inquiry, the authors hope to show that the data presented are both valid within context and relevant to future research development.

In the next section, linguistic research on emotional expression, autobiographical narrative and identity in bilinguals will be reviewed and linked to the literature on the role of language in therapy. This is followed by an outline of the research questions and methodology. Responses from 109 adults are then analysed and discussed in relation to the literature, and possible implications for therapy are put forward.

**Literature review**

For Grosjean, bilingualism is 'the regular use of two or more languages' (1982, p. 1). The present study focuses on participants' lifetime language history, including as bi- and multilingual those who have been fluent in more than one language at some point in their lives rather than focusing on current language proficiency or usage.

***Multilingualism and self-expression***

*Multilingualism and emotion*

Pavlenko (2005) and Dewaele (2008, 2013) analysed data from the Bilingualism and Emotions Questionnaire (BEQ) to which more than 1579 bi- and multilinguals contributed quantitative and qualitative data. Dewaele (2013) focused on over 300 pentalinguals who answered the question 'What language do you express your deepest feelings in?'. Overall participants reported a strong preference for languages acquired earlier in life. The age of onset of acquisition was also a factor in the likelihood of participants choosing their foreign language (LX) for emotional expression, while the context of acquisition was a significant factor across all five languages. Dewaele concluded that early acquisition and a mixed or naturalistic learning environment could lead a language to 'take on the emotional resonance usually associated with the L1' (p. 105). However, in a different subsample of 386 multilinguals who considered themselves maximally proficient in both their L1 and L2,

used equally frequently, Dewaele (2011) still found a general preference for the L1 for communicating feelings.

Dewaele (2015) looked at BEQ respondents' language preferences for inner speech and emotional inner speech. They reported a clear preference for the L1 for inner speech and emotional inner speech, with LXs being used gradually less frequently.  These LXs were used more frequently for inner speech than for emotional inner speech, which suggests that it can take some time before an LX gains emotional resonance (Dewaele, 2015). Increased use of the LX for inner speech and emotional inner speech was found to be linked to higher levels of self-perceived proficiency, general use, LX socialization, LX emotionality, lower age of onset of acquisition and context of acquisition. The findings suggest that an LX 'can evolve from an obscure echo of social interactions […] to a language of the heart' (pp. 15-16). Pavlenko (2012) proposes that L1 and LXs elicit different levels of emotion because of differences in the language acquisition process, leading to a phenomenon she terms 'language embodiment' (p. 456). According to this theory, infants' 'conceptual development' and 'affective linguistic conditioning' (ibid.) develop concurrently to form powerful associations between the mother tongue and early memories, sensations and emotions. LXs lack these rich emotional associations and may therefore be perceived as detached and disembodied by the LX users.

*Multilingualism and autobiographical narrative*

Schrauf (2000) reviewed experimental psychology studies and psychoanalytic therapy records and concluded that childhood memories are 'more numerous, more detailed and more emotionally marked' (p. 387) when recounted in the first language. Congruence between language of encoding and language of recall was found to increase emotional intensity in the telling of autobiographical memories in Marian and Kaushanskaya's later study (2004). More recently, Altman, Schrauf and Walters (2013) reported that mature English–Hebrew bilingual immigrants code-switched more frequently when retrieving 'memories in a language that differed from the language of the experimental session and cue word' (p. 211).

Koven elicited autobiographical stories from French-Portuguese bilinguals in both languages and found differences in their accounts, as well as how they perceived themselves and were perceived by listeners, concluding that (1998, pp. 436-7): 'In switching languages, they switch between speaking through different locally recognizable personas in the French-speaking and Portuguese-speaking contexts in which they circulate and which they can summon up in speech.'

*Multilingualism and identity*

Pavlenko (2006) conducted a quantitative analysis of responses to the question (p. 10): 'Do you feel like a different person sometimes when you use your different languages?', featured in the BEQ.  She found that two thirds of those who gave a valid response (1,005 multilinguals) answered in the affirmative. Dewaele (2016) analysed these further and found that even simultaneous bilinguals report feeling different in different languages.  Different dimensions were explored by Dewaele and Nakano (2012), who asked 106 multilinguals to evaluate how they felt in each of their languages. Analyses revealed a significant effect of the order of acquisition, with a gradual decrease in how logical, serious and emotional participants felt and a gradual increase in feeling fake when they used later learned languages (L2, L3 and

L4) compared to their native language(s). Wilson (2013) combined items from the BEQ with a personality questionnaire and sampled British learners of French. She found that 'a foreign language can give shy people a mask to hide behind even at fairly modest levels of proficiency' (p. 305).

### *Language and therapy*

Bilingual clients' language associations and practices have long been noted by psychoanalysts. In Buxbaum's seminal article on her work with German-English bilinguals she describes the impact of language choices (1949, p. 286): 'verbalizing experiences in the language in which they occurred makes them become real; speaking of them in any other language renders them unreal'. Dewaele and Costa (2013) is one of very few studies to have directly investigated the multilingual client's perspective. Reporting on an international sample of 182 multilingual clients, they concluded that multilingualism was 'an important aspect of their sense of self and of their therapy' (p. 41). Participants valued being able to express themselves in their language(s) of choice in the therapeutic setting, including by code-switching.

### *Language disclosure*

In the UK service users who do not speak English are entitled to assistance from an interpreter. However, there is no national requirement (from the National Health Service or professional bodies) to provide a service in the client's first language, or other preferred language, if the client speaks English. Instead small specialist services offering counselling in community languages or the languages of refugees are often provided by charities. A report prepared for the Welsh Government and the Care Council for Wales (IAITH, 2012) highlighted a 'failure to take account of the language profile of users and workers' (p. 21) and cited in their evidence a Welsh-speaking mental health service user who had not known that her psychiatrist spoke Welsh until her treatment had ended. Another patient described how she had the opportunity to use Welsh with her psychiatrist after a chance discussion linked to her occupation: their common Welsh ability, and her preference for Welsh, had not been established prior to, or at the start of, treatment.

Pérez Foster (1998) recommended that therapists identify their client's 'Psycholinguistic History' (p. 108), starting with 'Psychodevelopmental factors' (ibid.) including the age and context of acquisition for each language and moving on to current language usage such as domains, interlocutors, 'Experience of self when speaking each language' (ibid.) and inner speech. Costa (2010) advises that therapists discuss language proficiency as part of the assessment phase and suggests prompts such as 'In which language is it easier to get angry/express affection/be professional?' (p. 20).

### *Client language practices*

The following example from a Welsh speaker who received English-medium counselling illustrates the sense of detachment a person can experience when unable to use their preferred language: 'I felt unreal talking in English… If she spoke Welsh, we would have reached somewhere else' (IAITH, 2012, p. 24). Another, quadrilingual, client whose first language was English argued that she needed to express herself multilingually in therapy (Dewaele & Costa, 2013, p. 41): 'a huge part of me just doesn't go to therapy with me. I have different personas with each language I speak so only speaking in English in therapy isn't helpful'.

Costa (2014) identifies four functions of language choices in therapy: identity, expression, defence and protection. Some clients choose a non-native language to express something which was taboo during childhood, as described by a counsellor in Costa (2010, p. 20): if expression of anger was not allowed when you were growing up, you may find that you can access and express this emotion in another language, which you have learned after your early, formative years.

Alternatively, where trauma has been experienced and encoded in the mother tongue, the client may use a second language as a 'protective function' (Costa, 2010, p. 20). Pérez Foster warns that language choices which are not attended to can turn into 'language-related resistance in the treatment' (1998, p. 220). For example a client who engages fluently in therapy in a later learned language may be employing a defensive strategy 'to isolate disturbing elements of affective experience lived in the first language' (ibid.), unbeknown to the therapist.

In their international survey of 101 therapists, Costa and Dewaele (2012) found that none of the respondents (18 monolingual and 83 multilingual therapists) had taken the step of 'inviting other languages into the therapy' (p. 9) with multilingual clients. Yet on reflection the three therapists who were subsequently interviewed were open to the idea of trying this in recognition of multilinguals' 'different linguistic identities' (p. 33).

*Code-switching (CS)*

Dewaele and Costa (2013) found that clients reported code-switching both in order to access certain emotions, and on the contrary as a distancing device, although 39% had disagreed that their CS was driven by increased emotional intensity. Language switching was empowering for clients, who could 'manage the emotional flow themselves' (p. 45). Dewaele (2013) quoted a BEQ participant who switched from L1 Greek to L2 English in therapy:

> when I talk about emotional topics I tend to code-switch to English a lot. I remember when I was seeing a psychologist in Greece for a while I kept code- switching from Greek to English. We never really talked about this […] To my mind it may have been some distancing strategy. (p. 206)

In addition to inviting the client to switch, or creating an atmosphere in which the client feels comfortable code-switching, the therapist's response to the utterance spoken in another language is important. Dewaele and Costa (2013) cite a client who switched languages to quote a painful memory but, not knowing whether or not the therapist understood French, felt 'more alone than when I explained in English' (p. 43) as the emotionally charged words were met with the therapist's silence. The client could not gauge whether or not the therapist had grasped the phrase's 'various connotations' (ibid.) and impact. This suggests that switching to a foreign language needs to be acknowledged and meanings needs to be explored together since a shared understanding cannot be taken for granted as it would be in a shared language.

**Research questions**

The study explores the following questions from the multilingual client's perspective:

1) to what extent are client (and therapist) language profiles identified and discussed in therapy?

2) which languages do multilingual clients use in therapy?

3) what causes clients to code-switch, and what part do therapists play in enabling or disabling this?

## Methodology

### *Questionnaire*

This paper is based on data obtained through a questionnaire as part of a mixed methods study for a PhD degree in Applied Linguistics by the first author.

A draft version of the questionnaire was reviewed by trained volunteers with experience of mental health problems through the Feasibility And Support to Timely recruitment for Research service: a free, confidential service for researchers in England provided by the National Institute for Health Research Clinical Research Network via King's College London. A revised version taking into account their comments received ethical approval from Birkbeck College and was piloted on line using Google Forms with eight participants (including six bi- and multilinguals). This led to the reformulation of some items and the rephrasing of some questions.

The survey was launched in January 2016 and remained online for four months. It was open to adults who had received one-to-one counselling or psychotherapy in any spoken language, and who could complete the survey in English (since no specific language combinations were targeted).

Recruitment was carried out using a combination of snowball sampling (through personal and professional contacts), general and purposive sampling (through public and professional fora). In particular, it was advertised to bilingual communities (e.g. language groups on social media, migrant community organisations, cultural institutes), mental health service user communities (e.g. internet forum http://www.mentalhealthforum.net/, charity-run education and activity centres) and mental health professionals (e.g. Mothertongue's Bilingual Forum for Therapists and Interpreters, students on counselling and clinical psychology courses). The study was primarily advertised by internet, although posters and leaflets were also distributed in London. For ethical reasons, participants were not targeted through patient routes. Participants were self-selecting and could choose to complete the survey anonymously.

## Sample

The present study focuses on the data of 109 bi- and multilingual[3] participants (92 females and 17 males) who reported on their language use in therapy. Participants were predominantly White (*n* = 82), with the next largest ethnic group being Asians (*n* = 8), and their age ranged from 18 to 80 years (Mean 40.6). Respondents held nationalities from 42 different countries; over a third (*n* = 33) were bi-nationals while some (*n* = 4) held three nationalities. The most frequently reported were British (*n* = 37), French (*n* = 21), German (*n* = 10), Spanish (*n* = 7 and American (*n* = 6). Nearly

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[3] The remaining 66participants were monolinguals who are not included in the present study.

two thirds (*n* = 70) were resident in the UK at the time they completed the survey, while the remaining participants lived in one of fourteen other countries (*n* = 14 in France and *n* = 5 in the USA).

The majority of participants were highly educated: over two thirds (*n* = 77) had or were studying for a postgraduate degree (Master's or Doctoral degree). Only two respondents had stopped at GCSE (or equivalent) level. Many respondents were students (*n* = 47), of which a third were trainees in the psychology professions; the next most frequent occupational groups were educators (*n* = 19 teachers and *n* = 9 academics) and psychology professionals (*n* = 25) – the latter included counsellors, psychologists, clinical psychologists, psychotherapists, psychiatrists, and psychoanalysts. Some participants had retired (*n* = 11).

Participants reported having 'some knowledge of' up to nine languages or dialects at the time of their latest therapy.  Nearly a third had learned another language before the age of 3 (listed here as L1b), that is, were simultaneous bilinguals. Table 1 details the number and proportion of participants who reported learning an LX.

Table 1. Language profiles of participants

| LX | Number (%) of participants with LX | Number (%) of simultaneous bilinguals with LX |
|---|---|---|
| L1b | 32 (29.4%) | 32 (29.4%) |
| L2 | 105 (96.3%) | 28 (25.7%) |
| L3 | 73 (67.0%) | 16 (14.7%) |
| L4 | 44 (40.4%) | 9 (8.3%) |
| L5 | 12 (19.3%) | 5 (4.6%) |
| L6 | 4 (3.7%) | 2 (1.8%) |
| L7 | 2 (1.8%) | 1 (0.9%) |
| L8 | 1 (0.9%) | 1 (0.9%) |

The most frequent first language (L1a or L1b) was English (*n* = 47); this includes British English and American English, although only a minority of participants specified a variety. Varieties of English had also been learned as an L2 (*n* = 48), L3 (*n* = 12) or L4 (*n* = 2) – only the first occurrence of English is counted here. Other frequently reported languages include French (*n* = 69), German (*n* =37) and Spanish (*n* = 30); overall many languages and dialects, from Arabic to Mauritian Creole, had been learned to varying levels of proficiency, in a range of environments (naturally, in an instructed or mixed environment).

Participants reported being 'fully fluent' in their first language (L1a) (Mea*n* = 4.8, SD = 0.5) and most simultaneous bilinguals were highly fluent in their other first language (L1b) (Mea*n* = 4.4, SD = 0.9). The mean oral proficiency scores decrease gradually with each additional language until L7: (L2: Mea*n* = 4.1, SD = 1.2; L3: Mea*n* = 2.8, SD = 1.4; L4: Mea*n* = 2.3, SD = 1.2; L5: Mea*n* = 2.2, SD = 1.4; L6: Mea*n* = 1.0, SD = 0.0; L7: *n* = 2, Mea*n* = 1.5, SD = 0.7). Overall, nearly half (48.6%) considered themselves fully fluent in two languages and a seventh (13.8%) had mastered three languages fully at the time of their latest therapy. Participants varied widely in their reported use of code-switching in everyday exchanges (Mea*n* = 3.2, SD = 1.6).

As for participants' private thoughts ($n$ = 106 answered this question), they tended to be expressed daily in their first language(s) ($n$ = 92), often in combination with later languages ($n$ = 43). Overall, nearly half ($n$ = 50) reported daily inner speech in two or more languages. Similarly, of the sixty-eight participants who reported keeping a diary or journal at the time of the therapy, nearly half ($n$ = 30) wrote exclusively in a first language and two people combined both first languages, while others used only later languages ($n$ = 15). The remainder ($n$ = 21) mixed first and later languages. Indeed one trilingual commented that she 'Always struggle to write my thoughts because I never know which language to write in. So I use all in different contexts'. Languages reported for daily inner speech and diary entries matched exactly for the majority ($n$ = 38) of those who completed both items ($n$ = 66) and overlapped in most other cases ($n$ = 26),

When asked 'How did you think of yourself as a language user (including dialect)?', approximately half ($n$ = 58) the participants responded that they considered themselves 'bilingual' while a third ($n$ = 36) identified as 'multilingual' at the time of the therapy. Some ($n$ = 14) considered themselves 'monolingual' – this may seem to contradict their reported fluency in more than one language but can be explained by the subjective nature of identity as well as the fact that they were not born with two languages (except for one participant, who switched between two varieties of Spanish) (see Sia & Dewaele, 2006).

The therapy sessions reported on by participants took place in 19 different countries, although the UK was the most frequent ($n$ = 61). Comparing the official languages of these countries with participants' language histories shows that many ($n$ = 49) undertook therapy in a country where their first language was not among the official languages. Those who responded to the next item indicated ($n$ = 38) that they had lived an average of 13 years in the foreign country (SD = 12) at the time they completed their therapy.

Over half ($n$ = 62) of participants were still in therapy at the time they completed the questionnaire. Accordingly, many ($n$ = 42) had had a therapy session within the last month. Over a quarter ($n$ = 29) had last had therapy one to twelve months before so that overall two thirds of respondents had had therapy within the last year. A minority ($n$ = 9) were reporting on therapy that had taken place over five years ago. The length of the therapy varied from a single session ($n$ = 3) to more than twenty sessions ($n$ = 46), with the majority somewhere in between.

The most frequently cited types of therapy were psychodynamic / analytic ($n$ = 33), humanistic / integrative ($n$ = 15) and Cognitive Behavioural Therapy ($n$ = 16); nearly a quarter ($n$ = 24) of respondents answered 'don't know'. Nearly two thirds had seen a therapist in private practice ($n$ = 68), and less than a fifth ($n$ = 20) had accessed therapy through a state health care service (such as the UK NHS); other providers included university ($n$ = 11) and work ($n$ = 4). The most common reasons for seeking therapy were: anxiety ($n$ = 51), depression ($n$ = 42), stress ($n$ = 40) and relationships ($n$ = 38). Some – mostly psychology professionals and students – had undertaken therapy as a training requirement ($n$ = 14), exclusively so for nine participants.

Asked about how strongly language availability influenced their choice of therapist (where there was a choice), on average this had not been a strong factor (mean response of 2.2 on a scale of 1 to 5). Therapy type and location were typically

reported as much stronger factors (mea*n* = 3.7). Similarly, for those participants who were allocated a therapist (*n* = 46), the majority had been consulted on their preferences with regard to session times (*n* = 36) and location (*n* = 28) but few had been asked about language preferences (*n* = 7) or culture/ethnicity (*n* = 3).

The sample is necessarily skewed towards bilinguals who are English speakers, although not exclusively native speakers, with internet access. Recruitment of non-UK residents was slower due to the authors' professional and personal networks being mainly UK-based. As for the overrepresentation of highly educated females, it is perhaps to be expected in a study appealing to people's interest in languages and/or mental health, given that related professions attract a majority of women with relevant qualifications (Wilson & Dewaele, 2010). In these respects it is similar to the sample described in Dewaele and Costa (2013). The therapy characteristics also show it to be skewed towards private practice.

## Results

### *Language disclosure*

Slightly more than half of the participants (*n* = 59) replied 'No, never' as to whether or not they had discussed which languages they knew with the therapist. The qualitative data complementing this closed question reveals that several clients had seen no reason to discuss this since they were fluent in the therapist's language and regarded this shared language as sufficient to be 'mutually intelligible' (ID 53). However one comment also hinted at self-translation: 'I don't think about it unless I know I need or want to use another language despite sometimes thinking in a certain language for myself' (ID52). Another touched on how things might have felt if expressed in the L1: 'I was comfortable explaining whatever is happening to me in English, there were difficult times of explaining as it will upset me, but if I spoke my L1, I guess I would feel the same or worse' (ID40).

Others assumed that the therapist would not know their other language(s): 'I was not asked and she clearly did not speak any of my languages in my opinion' (ID43). Local socio-pragmatic norms also played a role in language choices: 'The first contact was done by sms in French as in Mauritius, it is more polite to use French for a first contact. English could have been used but would have been very formal' (ID85).

As for those who had this discussion with their therapist, nearly two thirds (*n* = 31) had it 'early in therapy'. For many the subject arose because of external signs of their background (such as accent, name or ethnicity) or as part of describing their personal history (e.g. family origins, countries lived in, profession). One participant wrote: 'talking about being bilingual came as a natural part of describing my identity and experiences'.

In some cases, language(s) and culture were discussed as part of the problem the client was seeking therapy for, such as 'to better understand and reconcile rejection of one of my two cultures, by significant members of family, and the consequences […] I will have talked about the fact that all my emotional language tends to be in one language only' (ID 6).

Some participants had been recommended this particular therapist for their language background.  This client explains how she took control of her language choices early on: 'I told her from the start that I wanted therapy to be in English – but that I consider her knowledge of Russian very helpful' (ID28). Others reported negotiating with the therapist:

> I'm a Catalan speaker, while my therapist's L1 is Spanish. I told him that I needed to speak in Catalan, but he could speak in Spanish, since conversations in which one speaker speaks Catalan and the other one Spanish don't bother me (that's how I grew up). He said he preferred to speak in Catalan, and he speaks it very well, but sometimes he switches to Spanish. (ID8)

Only 51 participants responded to a question about who had initiated this discussion; twenty recalled being the instigator and another twenty reported that it had been the therapist, while the others were not sure. One participant who had therapy in Sweden reported that: 'The therapist saw that I had filled in on a form that I come from Australia and/or have English as my first language and asked if I wanted to conduct the sessions in English.' Some therapists were reported to have disclosed which languages they knew ($n$ = 25); twenty-one participants listed at least two languages known by their therapist. Clients also reported on aspects of their therapist's background which would have given them clues as to the therapist's native language or familiarity with other cultures and languages, such as a foreign accent ($n$ = 20). In some cases, qualitative comments provided further language information where these questions had not been answered. Combining all three sources of information, there was evidence that at least thirty-four participants knew that their therapist was bilingual, although less than half of these ($n$ = 16) were known to share more than one language with their therapist.

While clients' language histories provided an opportunity to discuss and negotiate language options for the therapy as described above, the large majority ($n$ = 93) of participants reported that they had not discussed 'which languages or dialects could be used' in their sessions.

### *Language usage*

Participants were asked how frequently they spoke each of their languages in therapy sessions using 'whole sentences' (to distinguish from short switches examined later). Table 2 shows the language(s) or dialect(s) used in every therapy session, i.e. the main therapy language(s) – only one participant cited using two languages in 'most sessions' but neither in 'every session'. The majority ($n$ = 64) used only their first language(s) as the main therapy language(s); a further two participants combined their first language with another. Of those whose main therapy language(s) didn't include a first language, nearly three quarters ($n$ = 31) used their L2. Overall four participants listed two main therapy languages (none reported three or more); eight participants reported using an additional language in full sentences in 'some' or 'most' sessions.

Table 2. Main therapy language(s) or dialects

| Language | N | % | Cumulative % |
|---|---|---|---|
| L1a or L1b | 63 | 56.9 | 57.8 |
| L1a and L1b | 1 | 0.9 | 58.7 |
| L1a and L2 | 1 | 0.9 | 59.6 |
| L1 aand L3 | 1 | 0.9 | 60.5 |
| L2 | 31 | 28.4 | 89.0 |
| L3 | 8 | 7.3 | 96.3 |
| L4 | 2 | 1.8 | 98.2 |
| L5 | 1 | 0.9 | 99.1 |
| L2 and L5 | 1 | 0.9 | 100.0 |
| Total | 109 | 100.0 | |

A significant association (Field, 2013) between the country of therapy including a participant's L1 as an official language and the participant reporting L1 as a main therapy language was indicated by a Chi-Square test for independence (with Yates Continuity Correction), $\chi^2$ (1, $n$ = 107) = 80.7, $p$ < .001, *phi* = -.9. Indeed only seven (out of $n$ = 66) clients undertook L1-based therapy despite it not being a local language. Two of them accessed a therapist in their home country on line (using Skype), while the others had therapy provided by their employer, through private practice or their university. Similarly, all those who undertook LX-based therapy did so in an LX country.

Asked how often they had used each language 'in a limited way, switching just for a word or phrase', nearly two thirds of participants ($n$ = 69) reported switching to another language in 'some sessions' at least, often to more than one other language since overall up to five languages were spoken by some clients in therapy. Even taking into account these short switches, nearly a fifth of participants ($n$ = 20, across sixteen different native languages) reported never using their first language(s) in therapy. However a Chi-Square test for independence (with Yates Continuity Correction) did not reveal a significant association between the main therapy language (L1 or LX vs. LX) and client-reported code-switching in therapy, $\chi^2$ (1, $n$ = 106) = .12, $p$ = .73, *phi* =-.54.

Qualitative data from responses to the next question 'Did the therapist do or say anything which made you feel that spontaneous language switching was allowed (or not) in therapy?' indicate that some clients switched spontaneously. One participant first assessed the therapist's reaction to, and understanding of, the other language: 'I tried it first. I saw the therapist was not shocked and understood (he looked foreign) and I knew I could switch to creole' (ID85). Another switched regardless of the therapist's fluency: 'I never knew what her level of English was but I tried and switched, and explained' (ID10).

Other participants were enabled by the therapist's interest in their language, shown for example by exploring 'phrases and their origin and meaning for me' (ID82). Some reported being asked to switch to their L1: e.g. 'she would often ask what a particular word was in English or ask me to associate in English' (ID99) and 'she actually asked me to say it in French, when I was translating it into English' (ID5). In contrast, one therapist reportedly translated her client's L1 speech back into the main therapy language (the client's L5): 'She tried to find matching words in Swedish where she felt this was appropriate or where she felt there was a synonym in

Swedish, which might be interpreted as discouraging free switching, but she did use my English word where she felt this was appropriate' (ID71).

None of the participants mentioned the therapist's bilingualism as a factor in their code-switching. Yet a Chi-Square test for independence indicated a significant association between awareness of therapist bilingualism (as defined above) and whether or not clients reported code-switching in therapy, $\chi^2$ (2, $n$ = 101) = 12.64, $p$ = .002, *Cramer's V* = .35 (medium effect size). This was driven by the fact that all the clients who reported sharing at least two languages with their therapist ($n$ = 16) code-switched in their therapy. Those who shared just one language with a bilingual therapist were more likely to have code-switched than those who did not consider their therapist to be bilingual, however this difference was not statistically significant at the 95% significance level.

For clients who had never switched languages in therapy, several responses highlighted assumptions (potentially justified) about the therapist's understanding: 'I don't speak French with people I don't think they know French, and that was the case with this therapist' (ID17). The client's own fluency in the therapy language was also offered as an explanation: 'there was no need to switch' (ID88).

### Reasons for CS

Fifty-one participants reported further about CS patterns. Frequency within a session ranged from 'rare' to 'very frequent' but was low on average (*mean* = 1.8 on a 5-point scale, SD = 1.08). Out of twelve listed options, CS was used most frequently for words or phrases difficult to translate ($n$ = 48, mean = 2.5, that is, between 'occasionally' and 'frequently', SD = 1.3), to express emotions ($n$ = 48, mean = 1.8, SD = 1.4), access memories ($n$ = 46, mea$n$ = 1.5, SD = 1.2), repeat someone's words ($n$ = 46, mean = 1.5, SD = 1.4) or mirror frequent CS in daily life (mean = 1.4, SD = 1.2). On average CS was rarely used for reasons of fluency (mean = .98, SD = 1.2) or 'to connect with the therapist' (mean = .74, SD = 1.3) and never to avoid a cultural taboo (mean = .28, SD = .9) or control the client's emotions (mean = .28, SD =.8).

The top four reasons are also salient in the qualitative data describing 'a typical (or memorable) language switch'. Thoughts which could not be translated satisfactorily caused a switch, whether for a single word as in 'I brought up the theme of rejection […]. I felt that there wasn't any good equivalent in Swedish' (ID71), or for an expression: '"nu bann - zot bann" which literally means "our group - their group" and which refers to the ethno-centric trend in Mauritius. […] The expression in creole cannot be translated really as it loses the local meaning...' (ID85).

In particular, one participant highlighted that her first language provided her with a more satisfactory word: 'DUSHA (the soul) – a common expression opening a world of its own in Russian, in contrast with 'mind' and especially the clinical "mental health" in English' (ID 28). Another participant described an attempt to explain a word which failed because it was a cognate with a different meaning in the therapy language:

Using the German distinction between the concepts of "Seele" and "Geist" to explain how I felt about something. I tried to explain how these concepts differ, it led to some

unclarity though, because the therapist interpreted the word "Geist" as it is used in Swedish. The misinterpretation felt unfortunate. (ID3)

In contrast, one participant described switching for the therapist's benefit: 'using British vocabulary instead of American so that the therapist would understand me' (ID53).

CS was used in order to fully express the emotions associated with particular phrases, which were often quotes from other people, as in 'painful phrases from childhood (e.g. 'Make yourself scarce') have little emotional resonance when translated so throughout therapy I always said them in English' (ID99) and 'Bella, brava, buona': mantra recited to me as a little girl […] Using the precise words helped me to get in touch more deeply with the associated feelings' (ID8).

Memories, especially relating to childhood, were evoked through the language of the experience, for example: 'I often think about my younger childhood in Dutch as I was living in Holland' (ID52) and 'poetry albums from my childhood and teenage years, which are in German' (ID66).

Certain words were used to embody people themselves:

I refer to my maternal grandmother as my "Mormor" in therapy (this means mother's mother in Danish). It feels good to be able to use what is, for me, the right word. It would be strange and alienating to refer to her as my grandmother or maternal grandmother. To me, she is my Mormor. (ID95)

The distancing and protective functions of CS were described by this client: 'when bringing up a memory about a broken/breaking relationship and describing this I might describe something in German. Often it could be to hide behind telling my therapist how I was feeling. It would feel ok – and safe' (ID18).

Some clients experienced a deeper connection as the therapist entered their world: 'a sentence from Light in August by Faulkner which was paraphrased into French and which the therapist copied down in English. Was happy to share this moment with the therapist and see the reactions' (ID78). Surprise was followed by relief: 'I was pleasantly surprised when my therapist asked me to say it in French. It felt she wanted that part of me not to be neglected or suppressed' (ID5).

However switching into another language can also make participants feel vulnerable, as explained by a Chinese client who pronounced her own name when asked its meaning by the therapist: 'I think I felt a bit exposed, and a bit alienated from my therapist for a moment' (ID47). These comments suggest that language has the power to transport the speaker to a different place, and depending on how this is handled the client may be able to share a different part of themselves with the therapist, or may find themselves disconnected, alone with their memories and inner self.

Despite their own use of language switching, nearly two thirds of this sub-sample ($n$ = 33 of 51) considered that their therapy had been 'monolingual' – including five participants who reported that their therapist knew two of their languages – and a further quarter ($n$ = 13) that it had been 'mainly monolingual'. It may be that although these clients spoke more than one language in therapy they did not regard the

therapy as bilingual because CS was infrequent or because the therapist did not engage in CS.

**Discussion**

As mentioned above, the language practices reported here should be taken within the context of a sample with particular features, such as an overrepresentation of White, highly educated women resident in the UK, with access to the internet, who undertook therapy in private practice. Nevertheless it is quite heterogeneous in terms of the language combinations spoken and other therapy characteristics.

The answer to the first research question on language disclosure is that client language profiles were not routinely discussed in therapy. Just over half of our participants had never had this discussion with their latest therapist. Given that these participants have experienced therapy in a variety of countries and contexts (public and private), it seems that the situation in the Welsh NHS (IAITH, 2012) is not isolated. Only one participant mentioned that her native language was recorded on a form, indicating that a systematic process was in place for identifying participants' linguistic background (in Sweden). Many others pointed to obvious signs of their bilingualism or biculturalism as having prompted the discussion, which raises the question of whether or not those with 'invisible' bilingualism are more likely to slip through the net. It is possible that some therapists detected aspects of their client's language profile without the need for an explicit discussion, however any assumptions they made may not have been accurate, just as clients may have been mistaken when they assumed that the therapist would not understand their language (less than a quarter of therapists had disclosed their language repertoire). Failure to identify client bilingualism necessarily leads to a narrower set of language options for the therapy, and falls short of the best practice recommendations of experienced bilingual therapists (Pérez Foster, 1998; Costa, 2010).

In response to our second research question, client language practices in therapy were varied. While the majority mainly used their first language(s), a significant minority – over a third – relied on a later language. This appeared to be attributable to living circumstances as very few reported accessing therapy in a language other than the local language and in particular no-one reported this in state-provided therapy. Code-switching was prevalent with a ninth of the sample combining fluent use of two languages and nearly two thirds reporting short switches, regardless of whether the main therapy language was L1 or LX. It was also significantly more likely when client and therapist shared more than one language and tended to be more frequent with bilingual therapists who spoke other languages. Some participants had the confidence to switch languages according to their own needs, others told how they were explicitly encouraged by their therapist. A number of participants had chosen to speak monolingually, either because they felt comfortable doing so or because they had not considered the possibility of switching languages and translating for the therapist.

The third research question focused on code-switching in therapy and relied on a smaller sub-sample. It seemed that, on average, code-switching was 'occasionally' driven by emotional expression and never felt to be linked to the need to control emotion. Other factors such as untranslateability and accessing memories were cited as more frequent reasons, which may explain Dewaele and Costa's (2013) mixed

findings about CS and emotional intensity. CS to access memories suggests that clients were recalling experiences encoded in another language (Altman, Schrauf & Walters, 2013).

Clients reported feeling surprised but mostly appreciative when encouraged to code-switch by their therapist – none reported declining the invitation. A supportive response from the therapist was also important to sustain the client's confidence that code-switching was both permitted and understood, as a lack of engagement with the material could leave clients feeling vulnerable or detached from the therapist. As clients speak the words which make their past experiences or different selves come alive, a careful dialogue is needed to establish a shared understanding. This can be a very positive experience for the client, reinforcing the therapeutic relationship. While most of the qualitative data suggests that CS was motivated by a need for increased self-expression, there was also an example of CS being used to accommodate to the therapist's perceived proficiency, and another in which the client sought to avoid difficult feelings and 'hide' them from the therapist.

Almost a fifth of our participants reported never using their first language, even for short switches, and yet only a tenth reported never using their first language for inner speech. This raises the possibility that some clients may have restricted themselves to the therapy language in order to conform to perceived norms, or as a defensive strategy to avoid exposing their inner selves (Pérez Foster, 1998). Alternatively the topic under discussion may not have required them to draw on L1 memories or terminology.

We are aware of the limitations of this questionnaire study, including the reliance on self-report and the recall of past experiences. Also, the sample is not representative of any specific population. We did not elicit detailed examples due to the potential vulnerability of some participants as they completed the questionnaire remotely; however a follow-on interview study is planned to explore themes further, according to an explanatory sequential design (Creswell & Plano Clark, 2011). Additional questionnaire data, not reported here, include a scale of perceived therapeutic empathy which was administered to both monolingual and multilingual clients. In addition to investigating themes identified in this study, future research could focus on clinical populations, investigate actual language choices and include different therapy outcome measures to examine the impact of language practices.

**Conclusion and implications for therapeutic practice and applied linguistics**

Although the statistical distribution of the language practices described in this study cannot be generalised to the general population, the mixed methods data presented provide evidence and explanation of certain behaviours and highlight possible trends. Many bilingual clients, despite being constrained by the languages offered by local therapy providers, reported drawing on their wider linguistic repertoire in sessions – and not just to code-switch to their first language, or because they shared two languages with the therapist. However the study also illustrates how clients' language practices can be influenced by the choices offered to them, which depend on their bi- or multilingualism being identified and supported by the therapist, and by their own sense of confidence in their bi- or multilingualism.

One striking finding is that whilst most participants considered themselves to be bi- or multilingual and reported engaging in bilingual speech, the majority of these considered their therapy to have been monolingual. While bilingual therapy may be difficult to provide, this study suggests that client code-switching with post-hoc translation for the therapist can be satisfactory from the client's perspective. We would thus exhort therapists to make room for code-switching and for other languages with their bi- and multilingual clients in order to allow them to describe their experiences and exhibit their different selves more fully. Therapists may need training to work in this way, but this approach fits well with the principles of relational psychotherapy, in which the client is regularly considered to be the expert on themselves (Anderson & Gehart, 2007; Parker, 2007). Finally, since 'therapy talk' is present in other conversational settings (Sarangi, 2000, p. 2) we suggest that language policies need to consider practices with multilinguals – particularly in situations when the person may be under stress and when it is important for a personal narrative to unfold, such as in legal and medical settings.

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