Negotiating the language(s) for psychotherapy talk: a mixed methods study from the perspective of multilingual clients[1]

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Abstract

Multilingual clients can benefit from expressing themselves in more than one language in psychotherapy. Yet research suggests that language switching is typically instigated by clients, although some do not feel empowered to negotiate the language(s). This paper addresses how language options, from the main therapy language(s) to language switching, were negotiated between client and therapist, as reported by 109 multilingual clients. All participants

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completed a web survey and five participated in follow-on interviews. In addition, we reflect on the advantages of the mixed methods approach – particularly with regard to ethics and the explanatory sequential design. Analyses combine descriptive statistics and thematic analysis to elaborate on the trends identified in this international sample. Whereas some multilingual clients did not feel inhibited about using languages other than the main therapy language, for others the therapist played an important role in promoting multilingualism in the therapy room. Indeed, a lack of discussion surrounding language use – beyond such technical aspects as agreeing the main therapy language – was found to lead to assumptions about therapists' proficiency or the (non-)acceptability of multilingual language practices. By contrast, metalinguistic discussions which explored process and meaning were welcomed by clients and typically opened up ways to use languages; the study itself was a catalyst for self-reflection and productive discussions for one interviewee. Thus, the research provides further evidence, from clients, that developing therapists' metalinguistic awareness and competence and empowering multilingual clients to share their insights has therapeutic benefits.

Keywords: multilingualism, code-switching, language awareness, agency, mixed methods; client perspective

Introduction

> During my conversations with the community mental health service, no one asked if I wanted to speak to someone in Welsh. […] I think in Welsh, my illness happens for me in Welsh, and trying to convey that in English feels strange and unfamiliar. (Elin, 2017)

Elin's (2017) account of her struggle to use her preferred language in therapy highlights the need for discussions around language to take place at the start of any talking therapy with multilingual clients. Research has shown for instance that multilinguals hold different emotional associations for languages within their repertoire (Dewaele, 2013; Marcos, 1976). Thus, the language(s) used influences how multilingual clients express affectively charged material in psychotherapy, as has been observed by multilingual therapists (Amati-Mehler et al, 1993; Pérez Foster, 1998) and further evidenced by a small, but growing, field of research (Rolland, Dewaele & Costa, 2017).

There is some evidence that multilingual clients may not expect, or feel able to request, communication in a minority language in healthcare settings (Roberts, 2017). Some recent policies promote the rights of minority language speakers to access mental health care in their language of choice. However, multilingual services remain scarce and cannot span the diversity of community languages. We argue, therefore, that the focus should be on the therapist's willingness and ability to work through a multilingual therapeutic frame by paying attention to the languages – which may or may not be shared – within the dyad.

Pérez Foster (1998) highlighted the importance of identifying and discussing multilingual clients' language profiles early on in psychotherapy, even when they are fluent in the majority language, yet this does not happen systematically

(Roberts, 2017; Rolland et al., 2017). How then do dyads establish which language(s) may be used in the sessions, and in what way? This paper investigates the process from a client perspective, examining how language options – from the main therapy language(s) to the possibility of language switching – are negotiated between multilingual clients and their therapists in psychotherapy sessions. We also reflect on the contribution of mixed methods, namely how an 'explanatory sequential' design (Creswell & Plano, 2011: 81) consisting of a questionnaire followed by interviews allowed a sensitive topic to be explored both on a macro- and micro- scale, within a rigorous ethical framework.

Literature Review

Implications of multilingualism for psychotherapy

Building on case notes by pioneering therapists (Amati-Mehler et al, 1993; Buxbaum, 1949; Pérez Foster, 1998), research conducted with multilingual therapists (Costa & Dewaele, 2012; Santiago-Rivera et al., 2009) or clients (Cook, 2019; Dewaele & Costa, 2013; Pérez-Rojas et al., 2019; Rolland et al., 2017) has reported on language practices within psychotherapeutic dyads.

Multilingual therapists have expressed concerns about the efficacy of therapy in a client's foreign language (LX) (Pérez Foster, 1998), which may dissimulate a resistance to the first language (L1) or – if imposed – be experienced as oppressive, as well as rendering L1-specific material inaccessible. Multilingual therapy – whether alternating between two shared

languages, or permitting switches to a language not known by the therapist – has been put forward as a means to regulate emotion, which can be used strategically by both therapist and client. In addition, it facilitates access to the client's language-specific memories (Santiago-Rivera & Altarriba, 2002) and hence integration.

Similarly, client-focused studies have described how language associations – developed through experiences and relationships in each language – impact on clients' ability to connect with memories and feelings or trauma which they seek to retell in therapy, and to reconcile different aspects of their identity. Code-switching in therapy is reported by up to two thirds of multilingual clients (Rolland et al., 2017) and stands out as a resource for emotion regulation (Dewaele & Costa, 2013), whether the main therapy language is an LX or an L1 (Rolland et al., 2017).

Language policies

A growing official recognition of minority languages has led to new language policies in bilingual regions, such as Wales, which seek to make health care accessible in the minority language. Yet, speakers do not typically expect this, or feel too vulnerable to request services in their L1 (Roberts, 2017). Hence the proactive policy of the 'active offer' which places the onus on service providers to identify clients' preferred language. Unfortunately, data on implementation of the offer and take-up are scarce (Roberts, 2017), and dedicated multilingual mental health services are limited.

Language disclosure and negotiation in mental health

In the absence of published data, it is difficult to establish the extent to which client languages are identified by mental health care providers, and preferences or possibilities for communication discussed. A few studies however consulted clients about their experiences.

Madoc-Jones (2004) found that whilst five mental health service users were known to be L1 Welsh speakers, only two had subsequently been offered contact in Welsh – both declined. They reportedly attributed their lack of insistence or take-up to fears of being perceived as 'awkward or politically motivated' (p. 221), due to the historical oppression of the Welsh language and identity. Similarly, an official consultation of mental health service users and other priority groups revealed 'low expectations and disempowerment' (Roberts, 2017: 123) regarding language.

Dewaele and Costa's (2013) open survey of psychotherapy clients was completed by 182 multilingual adults from around the world, of whom eighty-four had had a multilingual therapist. Participants reported that code-switching was more frequently initiated by the client. Building on this study, Rolland et al. (2017) surveyed 109 multilingual clients about their language practices in one-to-one psychotherapy. The majority (n = 59) had never discussed their language profile with their therapist. Many thought this unnecessary since they were fluent in the dominant language, or irrelevant since the therapist was unlikely to share their other language(s). However, some therapists had disclosed their own multilingualism; client awareness of therapist multilingualism was found to be associated with code-switching behaviours. Indeed, all those who shared two

languages with their therapist reported switches, and others felt enabled to speak another language with a multilingual therapist even though it was not shared. An open item probed the role of therapists (monolingual or multilingual) in facilitating language switching. Thematic analysis revealed that therapists' invitation or response to client code-switching played a part, in addition to client agency and the wider linguistic environment (such as attitudes to code-switching). Invitations to switch were always welcomed by clients, while a lack of response could be construed as permissive or dismissive, depending on the context.

Cook (2019)'s qualitative study explored the meaning which 15 members ascribed to using a later-learned language (English) within a UK-based therapeutic community for refugees and asylum seekers who have survived torture. All trauma therapy sessions took place in English. According to most participants, this met their language preference since the emotional detachment of the LX facilitated the disclosure of traumatic experiences, and many felt that the new language empowered them to reinvent themselves within this supportive community.

Finally, Pérez-Rojas et al. (2019) investigated eight bilingual Latinx clients' experience of using Spanish and English in therapy. One participant described asking his therapist early on in the therapy about using Spanish; being allowed to draw on both languages as he wished gave him a feeling of agency. Participants also described therapist actions which suggested a 'bilingual orientation' (p. 249): encouraging clients to switch languages, disclosing their own bilingualism, introducing a language switch, repeating clients' speech in the same language and querying clients' motivation for switching languages.

Moreover, clients felt cared for when their therapist sympathised with a linguistic struggle or were willing to use Spanish despite being less fluent.

Practitioner recommendations

The literature by multilingual psychotherapists recommends establishing a client's languages and their significance for the therapeutic work (Costa, 2010, 2020) early on. Pérez Foster (1998) encouraged therapists to obtain information on the client's linguistic history, from the age and context of acquisition for each language to current language usage, including inner speech and their sense of self when speaking different languages. Additionally, Santiago-Rivera and Altarriba (2002) recommended exploring 'how and in what language emotions are experienced' (p. 36). Moreover, Roberts (2017) highlighted that linguistic agency also depends on the broader sociopolitical environment, which influences a language's 'power, prestige and status' (p. 118).

Regarding therapists' language abilities, although some practitioners advertise multiple working languages, the subject is not always broached. With an Argentinian patient undertaking analysis in Italian (Amati-Mehler et al. 1993), revealing other shared languages helped the patient to become aware of his defensive use of multilingualism as a way of escaping from interlocutors' grasp when he felt vulnerable, which he could no longer do with his analyst after discovering her proficiency. However, introducing a shared language once therapy is under way can be very delicate.

As for language switching, accounts from language-matched dyads vary from therapists directing switches for strategic reasons to following their client's lead.

Rozensky and Gomez (1983) report that asking '"Can you try in Spanish?"' (p. 165) helped a client to express her fear of dying, which she struggled to articulate in her L2 English (despite being fluent). Bi-/multilingual therapists interviewed by Santiago-Rivera et al. (2009) practised responsive code-switching and initiated switches if a word did not translate well from a cultural perspective, or as a strategy to address identity issues. Where only one language was shared, some multilingual therapists invited patients to express themselves in their L1 and give a *post hoc* translation (Costa, 2010). Others had not but were receptive to the idea (Costa & Dewaele, 2012). Pérez Foster (1998) advises allowing patients to initiate code-switching, observing patterns of language use to learn the role of each language. However, she adds that analysts themselves may strategically switch languages 'as a quasi-interpretive intervention' (p. 224) in order to prompt language-associated memories.

With regard to selecting the main therapy language(s), discussions between psychotherapists and their multilingual clients about which language(s) to speak in therapy are seldom reported in the literature. In case reports, therapists appear to agree to the client's preferred language if they share more than one language (Amati-Mehler et al., 1993). Although referrals are recommended by the APA (1990) if the preferred language cannot be met, they tend not to be discussed in the literature. One exception is Espín (2013), whose South American client consulting in the United States stated a preference for English: she had sought a 'culturally sensitive' (p. 198) therapist but did not wish to speak in Spanish.

Thus, approaches to language disclosure vary. As for the language negotiation process, it is seldom described explicitly. In language-matched dyads, clients

sometimes take the lead yet therapists may choose to direct which language is spoken at specific junctures. However, little has been published about how client languages which are not shared are invited into the therapy room.

Research Question

This paper addresses the following research question: How are language options, from the main therapy language(s) to code-switching, negotiated between client and therapist?

Methods

Quantitative methods are best suited to evaluating the prevalence and effect of different language practices in therapy, since 'idiosyncratic differences associated with the particular individuals are ironed out by the sample size and therefore the pooled results largely reflect the commonalities that exist in the data' (Dörnyei, 2007: 27). Meanwhile, qualitative methods are suited to investigating explanations for these patterns, through in-depth descriptions of individual cases. In a mixed methods design, each methodology can be assigned a specific, complementary role: 'offer[ing] researchers the unsurpassed advantage of binocular vision, allowing them to perceive three-dimensional images of phenomena' (Dewaele, 2019: 85). This has proved to be an effective tool for this particular research topic (Dewaele & Costa, 2013, 2014).

The doctoral,study (Rolland, 2019) from which this research is drawn follows an explanatory sequential design (Creswell & Plano Clark, 2011): a survey chiefly comprised of quantitative items, supplemented by a small number of qualitative

items (open questions), followed by an interview phase ‘designed based on what is learned from the initial quantitative phase’ ([p. 83). In such a design, theoretical assumptions necessarily ‘change and shift from postpositivist to constructivist as researchers use multiple philosophical positions’ (op. cit.: 83) when interpreting the data. We adopted a social constructionist lens (Patton, 2002) with regard to the qualitative data. From an ethical perspective, this two-stage mechanism was important since it allowed participants to decide whether they wished to participate in the second phase, in full knowledge of the topics involved.

Data Collection

Questionnaire

The full questionnaire contained sections on: participant background, language options and usage in psychotherapy, the therapeutic relationship and future therapy preferences. Initial drafts of the questionnaire and study recruitment poster were reviewed by the Feasibility and Acceptability Support Team for Researchers (funded by the National Institute for Health Research), who provided service user and carer feedback, in November 2015. A slightly modified on-line version was then piloted with eight acquaintances of the researcher, leading to further minor clarifications.

Due to the exploratory nature of the study, the survey was open to the general public rather than targeting potentially vulnerable clinical populations, between January and May 2016. Snowball sampling was carried out by email and through social media using our professional networks (linguists and psychotherapists) and the first author’s social networks: multilinguals with

experience of psychotherapy were invited to self-select. In addition, the study was advertised on the Mental Health Forum, a specialist internet forum, and posters were placed in several university buildings and community centres in London. Participants could choose to participate anonymously and to abandon the survey at any time. Finally, the study was advertised at a Mind drop-in support group in London, where hard copies of the questionnaire were made available.

Interviews

At the end of the questionnaire, participants could choose to be contacted with information about a follow-on interview. Of the forty-seven who expressed interest, eighteen were excluded for reasons such as: problem severity; fewer than four sessions with their latest therapist; more than five years since their latest therapy; being known to the researcher. The remaining twenty-nine candidates were grouped according to key features from the questionnaire data, such as whether or not they had used more than one language in therapy, had experiences with more than one therapist, and were in ongoing therapy.

An interview guide covering the same broad topics as the questionnaire was developed after initial analysis of the questionnaire data, and revised after a mock interview (in which the second author played the role of participant). Interview invitations followed an iterative process: each decision was informed by the content of the latest interview in order to explore different types of experiences. One goal was to include participants who reported no language switching in therapy in order to explore the context (e.g. whether they had felt

unable to negotiate a switch) and implications, since these were unclear from the questionnaire responses. Moreover, those in ongoing therapy were prioritised in order to facilitate the discussion of recent experiences. Thus, the sampling was purposive and the study interview guide was tailored to each participant. Minor revisions were also made following supervision debriefs, which took place after each interview.

In total, five participants were invited for a 1-hour face-to-face meeting at the university (a safe and confidential setting) if possible, however three participants requested a Skype interview. These took place between August and December 2016.

Language(s)

The questionnaire was administered in English since no specific language combination was targeted and experience of therapy in the UK was of particular interest; in addition, English is widely used as a foreign language.

It was decided to carry out some interviews with participants whose L1 the researcher spoke, namely French (L1b) and Italian (L3), to allow participants to draw on their full linguistic and affective repertoire (Rolland et al., 2019). For the final interview, the researcher prepared by creating a bilingual English-French version of the interview guide. Interviewees were greeted in English; however, the researcher soon disclosed her own language proficiency (or lack thereof) and background as an early bilingual. The French and Italian participants were given a choice of interview language, while participants with whom English was the only common language were invited to make switches to

their other language if they wished to, before explaining in English. In fact, one participant made occasional switches to Spanish, which she then summarised, and one interview was carried out mainly in French, with both interviewer and interviewee making switches to English.

Data management

The survey platform used was Google Forms, resulting in the data being hosted on the researcher's password-protected Google Drive and subject to Google's Privacy Policy. Survey participants' contact information was stripped from the questionnaire data before analysis and saved separately, and securely, as an ID key. After each interview, audio recordings were transferred and stored securely. In order to preserve interview participants' anonymity, certain details have been omitted in this report and aliases have been used.

Ethics

The research received ethical approval from Birkbeck College, University of London, for both the questionnaire component (in 2015) and the interviews (in 2016).

Data Analysis

Quantitative

Quantitative analyses were carried out using the Statistical Package for the Social Sciences (SPSS).

Qualitative

While the questionnaire contained free text typed by participants, the interviews were audio-recorded. Recordings were transcribed by the researcher and annotated with observations on paralinguistic features and nonverbal communication, as part of the analytic process (Braun & Clarke, 2013). Initial translations (into English) were discussed with a Spanish-speaking supervisor and an L1 English speaker residing in France to arrive at a final version.

Thematic analysis (Braun & Clarke, 2006) was used with qualitative data from both the questionnaire (although limited by the brevity of responses) and interviews. Following Braun and Clarke (2006)'s framework, the analysis progressed through six stages (p. 87): 'Familiarizing [one]self with [the] data', 'Generating initial codes', 'Searching for themes', 'Reviewing themes', 'Defining and naming themes', and writing up the analysis with selected quotes. An inductive approach was chosen in order to explore all the topics in the data. Coding was carried out primarily at the semantic or explicit level; interpretation followed at the thematic stage. For the interviews, this was facilitated by NVivo software.

Participants

The study involved 109 adult multilinguals, aged 18 to 80 years (M = 40.6), who had experienced individual psychotherapy or counselling. Participants were predominantly female (n = 92) and White (n = 82), with Asians (n = 8) forming the next largest ethnic group. Overall, forty-two nationalities were represented. The most frequently reported were: British (n = 37), French (n = 21), German (n

= 10) and American (*n* = 6); others were citizens from Asian, African, South American and Australian countries. Nearly two thirds (*n* = 70) were living in the UK when they completed the questionnaire. The majority of participants were highly educated: over two thirds (*n* = 77) had or were studying for a postgraduate degree. Students formed a substantial contingent (*n* = 26), a quarter of whom were trainees in the psychology professions. Other professions included teachers and psychologists.

The overrepresentation of highly educated females and psychology-related occupations partly reflects the bias introduced through snowball sampling, but the former is not unusual for studies focusing on languages and mental health (cf. Dewaele & Costa, 2013).

Language profiles

At the time of their latest therapy, participants reported up to nine languages or dialects. Almost a third were simultaneous bilinguals, having learned another language before the age of three (labelled L1b). Table 1 shows the languages reported in order of acquisition.

English was the most frequently reported L1 (*n* = 47; L1a or L1b), with varieties such as American, British and Australian specified. For others, English was the L2 (*n* = 48), L3 (*n* = 12) or L4 (*n* = 2). Other languages prevalent across the sample include French (*n* = 69), German (*n* = 37) and Spanish (*n* = 30). Overall, many languages and dialects, from Arabic to Mauritian Creole, had been acquired in different environments to varying levels of proficiency.

Fluency was self-evaluated using a five-point Likert scale (where 1 = ‘minimal’, 5 = ‘fully fluent’). Participants were fully fluent in the first language listed (L1a) (*M* = 4.8, *SD* = 0.5) and typically highly proficient in any L1b (*M* = 4.4, *SD* = 0.9). The mean oral proficiency scores gradually decrease as the order of acquisition increases, until L7. Nearly half the sample (48.6%) estimated themselves to be fully fluent in two languages at the time of their latest therapy, while a seventh (13.8%) had mastered three languages. As for code-switching in everyday interactions, self-reported frequency on a five-point scale (where 1 = ‘never’, 5 = ‘very frequently’) varied widely (*M* = 3.2, SD = 1.6). Daily inner speech was typically in a first language(s) (*n* = 92 of 106 responses), often in combination with later languages (*n* = 43). Overall, nearly half (*n* = 50) reported daily self-talk in two or more languages.

Therapy profiles

A minority (*n* = 47) of participants were in ongoing therapy when they completed the questionnaire. Overall, two thirds of respondents (*n* = 71) had seen a therapist within the last year. Only a few (*n* = 9) were reporting on sessions which had taken place more than five years previously. The length of the therapy ranged from a single session (*n* = 3) to more than 20 sessions (*n* = 46). The most common modalities were: psychodynamic / analytic (*n* = 33), humanistic / integrative (*n* = 15) and cognitive behavioural (*n* = 16); however, nearly a quarter (*n* = 24) of participants could not specify one. Therapists were primarily accessed through private practice (*n* = 68); other providers included state health care services (*n* = 20) such as the UK NHS, universities (*n* = 11) and workplaces (*n* = 4). The most common reasons for seeking therapy were:

anxiety (*n* = 51), depression (*n* = 42), stress (*n* = 40) and relationships (*n* = 38). Some psychology professionals and students had undertaken therapy as a training requirement (*n* = 14).

Interview participants

Participants were five women who spoke English fluently as an L2 and had experienced psychotherapy while living in a foreign country. Table 2 displays key linguistic, demographic and therapeutic information. Marcela and Elena were both training to be psychotherapists; Marcela's latest therapy fulfilled a training requirement. All but Alicia are married to fellow countrymen, with whom they share a first language. Juliette has children and speaks to them in both French and English.

Results

Questionnaire data

Discussing language options

A large majority of participants (*n* = 93) reported that they had not discussed which languages or dialects could be used in therapy sessions. Below we report on an open question which invited participants to describe these conversations, or how they felt about their absence.

Nature of negotiations

Thirteen participants described how language options were negotiated with the therapist; the four themes identified in the analysis are listed in Table 3.

Two shared languages: agreeing main language and switching

Clients who shared more than one language with their therapist reported discussing which language to use as the main therapy language and the possibility of switching to other languages. In one dyad, the natural choice was their shared L1. By contrast, a Russian immigrant to the USA decided to use her L3 English. However, since she also valued her American therapist's knowledge of Russian (acquired while living in Russia), it was agreed that both should feel free to code-switch (ID28).

Two understood languages or dialects: allowing a mismatch

In some cases, the client and therapist agreed to each speak different languages (or dialects), since they could understand each other. For example, a simultaneous Catalan-Spanish bilingual who wished to use Catalan nevertheless offered her therapist a choice: 'I said that I absolutely had to use Catalan, but he could use Spanish' (ID8). The therapist chose to align with his client and was fluent enough to do so.

One shared language: confirming adequacy for therapy

Several clients whose therapists did not speak their L1 (or L1a) described minimal discussions in which they acquiesced to using the local language (English) as the main therapy language, without further options being suggested. In a Malayalam-English speaker's words: 'therapist asked if I am comfortable and I said I am' (ID174). This appeared to reflect shifts in clients' own language use: after living in the UK for nearly a year, one client reported no longer using German for his daily inner speech, while another still used both Spanish and English.

Code-switching to non-shared languages

A British national living in India who consulted a UK therapist via Skype recalled that she 'could mention salient words or phrases in Hindi' (ID150) before translating or explaining for the therapist. Her therapist's openness to this different language and culture – which were part of her current environment and experiences – put her at ease and enabled her to communicate her problems and emotions more authentically.

Feedback on lack of negotiation

A third of those who did not discuss language options commented on how they felt about this; in fact responses were mainly explanatory. Table 4 shows the three themes identified.

Unnecessary

Many participants did not perceive the lack of an explicit discussion as problematic. A common response was that the (main) therapy language was 'natural'. Often it was a first language for the client and the dominant local language. In addition, some LX speakers explained that it had become their dominant language. Multilingualism was framed as a question of fluency and languages considered to be equivalent: 'I speak several languages fluently and could have had my therapy in 4 languages, one as easily as the other' (ID27).

No choices to discuss

By contrast, other participants reported that the therapy language was inevitable and hence not worth discussing. The lack of linguistic alternatives was presented as fact: 'no options were available' (ID155, L4 therapy). The therapist's

monolingualism, whether known or perhaps assumed, was offered as an explanation by several participants: ‘it wasn’t a choice. My therapist only spoke one language’ (ID105, L2 therapy).

Not consulted

Some perceived the therapist to be in charge. In particular, two participants expressed a clear language preference for therapy, which they may not have discussed with their therapist. A Greek-English client described it as a short-term compromise: ‘Certainly would have preferred to speak in English, but as only French was available, I decided this was good enough for a few sessions’ (ID145, L2 therapy).

Interview data

The five participants reported disclosing, or being asked to disclose, their L1(s) in therapy. Some discussions about language possibilities took place; three themes were identified, as outlined in Table 5.

No discussion (language match)

Juliette shared two languages with her multilingual therapist, as a result of choosing to consult a French-speaking therapist in London. She had initially greeted the therapist in French, so that her L1 automatically became the main therapy language. However, she also reported code-switching to English, as did her therapist. Bilingual practices reportedly happened naturally without any discussion of rules to be followed, due to the speakers sharing two languages. Indeed, at the start of the research interview, Juliette commented: ‘I’m sure at some point we’ll be, you know, switching from French to English’.

Technical discussions

The other three participants in therapy in the UK had addressed their therapists in English from the start. They reported the following types of language discussions in therapy: identifying and recording the client's L1, confirming fluency in English, and welcoming the use of other languages.

Nabeela recalled being asked about her L1(s) when she started NHS counselling. However, she could not identify any action taken as a result, such as discussing therapy provision in her L1 of choice (with a bilingual therapist or through an interpreter) or code-switching, as needed, before translating for the therapist.

Both Marcela and Elena had felt insecure about having therapy in English and sought reassurance from their therapists. As Marcela explained: 'sometimes I feel I'm not making sense […] what she reflects is that my English is ok, that it's not a problem, she can understand everything I say'. Both were invited to use another language by the therapist if need be. Elena's current therapist offered: '"if you feel that you have to say something in a different language, do it"'. In fact, she did not wish to speak Italian since she preferred not to identify as Italian. Marcela's latest therapist reportedly said: '"Apologies, I cannot understand or speak Spanish so in that sense I won't be able to help you or talk to you or understand you if you use words in Spanish"'. However, she then qualified that she was willing to work with this unknown: '"by all means use them if you nee-, you have to, and then we'll see from there"'.

Alicia reported a different experience, living in Catalonia where her Peruvian Spanish, peppered with switches to English, was not always understood or welcomed. In trial sessions with a Catalan therapist who would sometimes use Catalan words (which Alicia could understand), she tried to accommodate her speech to the therapist. Alicia described how self-monitoring was a burden: 'you're going to have to be explaining, […] not slipping in words in English […], you have to, you know, speak slowly'. This cognitive work did not prevent Alicia from engaging with therapy, but it was nevertheless an obstacle which hindered her 'flow'.

By contrast, when she consulted a Mexican therapist, she felt comfortable using her L1 as Latin Americans are often familiar with other Spanish varieties. Indeed, she estimated that the therapist only queried her meaning 'a couple of times' over eighteen months. Asked how the use of English with her Mexican therapist was negotiated, Alicia initially recounted asking directly whether the therapist spoke English, which she did. On probing, she recalled that in fact the therapist had commented on Alicia's inadvertent use of English, leading Alicia to ask whether this was problematic and the therapist to reassure her that it was not.

(Re)negotiating upon consideration of language processes

Prior to participating in this study, none had explored language associations and their implications for therapy with their therapist. However, completing the questionnaire prompted Elena to reflect on her discomfort with the Italian language, which was linked to identity problems, and her avoidance of it in psychotherapy. Interviewed several months later, she described the changes she

had made in her therapy (which was ongoing) as a result. She had started to use ‘some terminology’ in Italian, developing a process which involved both writing and speaking in Italian: ‘I usually either write it down, or thinking about it myself. And then I might mention some words, but not sentences, words, relevant keywords – and then I translate the feeling’. This prompted discussions with her therapist about her earlier language avoidance and desire ‘to distance from some experiences’. The shift to using Italian allowed her to access and disclose certain aspects of her childhood – such as fairytales and poems – for the first time, ‘reconnect[ing] with parts of myself that I didn’t either explore, or I didn’t want to explore’. Yet she was unable to tolerate her therapist mirroring these words, and wished to remain in control of how Italian was brought into the therapy.

Discussion

Most participants reported no explicit discussion about which languages or varieties were permissible in therapy; whilst not surprising for the small majority who had never discussed their language profile with their therapist (Rolland et al., 2017), it suggests that many others did not progress from revealing their languages to establishing linguistic norms for the therapeutic conversation. We note that this result cannot be generalised to the general client population since the survey sample was not random, however it is consistent with a lack of metalinguistic discussions in the literature.

Two shared languages

When two languages were shared, discussions centred on choosing the main therapy language. This was typically the client's decision, in keeping with other recent examples (Espín, 2013; Pérez-Rojas et al., 2019). While some opted for their L1, others were most comfortable in the LX, suggesting that it had become the 'language of the heart' (Dewaele, 2013). However, one client had accommodated to the therapist's language in order to optimise communication. The main therapy language could also be established simply through a greeting in a shared minority language, as in Juliette's case.

The freedom to code-switch to the other language was either mutually agreed, asserted spontaneously through language use, or proposed by the therapist (see also Rolland et al., 2017). Juliette interpreted her therapist's code-switching as motivated by her own expressive needs rather than any therapeutic reasons, despite some therapists reporting it as a strategic tool (Pérez-Foster, 1998; Santiago-Rivera et al., 2009).

One shared language or dialect

Receptive multilingualism, whereby each person speaks their own variety while understanding that of their interlocutor, is to our knowledge not mentioned in the psychotherapy literature. It allowed some clients to speak a different language or variety from their therapist, suggesting that dyads can have a broader range of options for communication when language pairs have acceptable levels of mutual understanding (Gooskens et al., 2018), if they are flexible. Yet these initial

negotiations focused on facilitating language matches rather than clients' full language profiles (cf. Pérez Foster, 1998).

Other clients reported merely acquiescing to the default therapy language. However, working with the support of an interpreter can be productive when multilinguals wish to speak another language in therapy (Costa, 2014; Santiago-Rivera et al., 2009). Moreover, there is a growing number of multilingual therapists in the UK (Costa & Dewaele, 2012), albeit few are trained to work in other languages (Bowker & Richards, 2004; Costa, 2014).

There were several reports of therapists inviting clients to code-switch briefly to another language and provide a *post hoc* translation (as recommended by Pérez Foster, 1998; Costa, 2010). Interestingly, this was not taken up by Elena until the study questionnaire prompted her to reflect upon the implications of her language choices in, acting as a catalyst for change. The introduction of Italian thereafter had far-reaching implications. We argue, therefore, that language discussions are most beneficial when they go beyond technical aspects to explore 'the process and relational implications of working therapeutically across languages' (Costa, 2020: 71).

The study also highlights that code-switching can take the form of sharing written materials in another language. Indeed, displaying examples of 'private writing' (Pavlenko, 2014: 221) such as a diary entry or poem can open a window onto the client's inner speech. For Elena, it was a safe way to code-switch, as in Buxbaum's (1949) case study of Bertha, who brought in her German diary when

‘her anxieties decreased’ (p. 283), as a precursor to speaking in German (which she had abandoned on emigrating to the USA).

No options discussed

For the vast majority of participants, there was no discussion around which languages or dialects were acceptable in therapy. However, the qualitative data suggest that respondents focused on options for the main therapy language rather than the possibility of code-switching. The lack of negotiation was not seen as problematic: for many of those in LX therapy it was now their primary language. Clients emphasised their fluency and regarded languages as interchangeable means of communication, a conduit view of language which is contested (Pérez Foster, 1998).

Others accepted that the dominant language in their country of residence would naturally be the language of therapy, in keeping with minority language speakers’ expectations regarding health care (Roberts, 2017). In addition to institutional monolingualism, private therapists were often perceived to be monolingual – despite a lack of discussion (Rolland et al., 2017). One participant highlighted the therapeutic relevance of using the local language to discuss experiences lived and encoded in the same language, as noted in the literature (Pérez Foster, 1998).

Finally, in the study some clients reported a language preference or sense that they should have had a choice. In therapy, they appeared to exhibit ‘language deference’ as has been observed in Wales (Roberts, 2017). Thus, this study confirms that clients from language minorities – whether indigenous or migrant

languages – may lack the agency to request services in their main language (Roberts, 2017), particularly when under pressure from the intersection of oppressive language ideologies, their patient status and poor mental health.

Interviews yielded more insights into behaviours such as Alicia's inhibition of code-switching with the Catalan therapist, which was not addressed in therapy and contributed to her disengagement. This client perspective is a novel contribution to the literature, complementing evidence that code-switching is a valued resource (Dewaele & Costa, 2013; Rolland et al., 2017).

Study limitations

The study sample is biased towards certain socio-demographic features due to our non-clinical, non-random sampling. Whilst this has yielded valid insights into client experiences on a neglected topic, future research should aim to be more representative of multilingual clients by targeting a range of groups, including those accessing state-provided psychotherapy or counselling and BAME clients who may be less empowered to assert linguistic agency.

Furthermore, the small number of interviews conducted necessarily limited the range of experiences which were explored. In particular, the interviewees had all undertaken psychotherapy as migrants, leading to insider/outsider dynamics with their respective therapists which influenced language negotiations. Further studies could usefully focus on other contexts.

Finally, interviewees were L2 speakers of English being interviewed in the UK by an L1 speaker. Despite efforts to empower participants linguistically, these

differences may have inhibited reflections and discussions around any negative (language-related) experiences with English-speaking psychotherapists.

Conclusion

The present mixed-method study shines a light on the lack of discussion about language options for multilingual clients in psychotherapy, when they are fluent in the dominant language. The research charts the different ways in which multilingual clients approach the negotiation of language(s), from exerting a choice by selecting a multilingual practitioner or spontaneously code-switching to feeling disempowered and inhibited within a monolingual environment, via creative negotiations drawing on receptive multilingualism.

Many clients positioned the therapist as the gate-keeper of linguistic practices, a finding which reinforces the need to train mental health practitioners to feel confident to offer a therapeutic space where multiple languages are welcome, where the exploration of clients' linguistic histories is valued and where a multilingual therapeutic frame (Costa, 2020) is applied. Client feedback confirms that 'talking about the talking' (Costa & Dewaele, 2019) is productive and merits to be developed as a core skill for therapists.

Finally, the adoption of an explanatory sequential design allowed us to identify some general trends in the preliminary quantitative and qualitative analyses based on data from 109 participants (cf. Rolland et al., 2017), and provided a framework which facilitated informed consent for the interview phase. The findings informed the sampling and questions for the five interviews, which

allowed us to hear clients' voices and obtain a more detailed understanding of the unique circumstances they had encountered with their therapist. Moreover, they introduced a longitudinal element which demonstrated the potential impact of exploring language use with multilingual clients. Conducting a study across the disciplines of Applied Linguistics and Psychotherapy/Counselling allowed us to approach the subject in the round, deepen our knowledge and insights and model a method of cross-cultural learning.

Implications for Practice

- Ask about clients' linguistic history and their relationships with their languages. Create a space where they feel that questions about the languages you may share are welcome.
- Discuss language options: agree on the main therapy language(s) and explore code-switching to other relevant languages (before translating if necessary).
- Talk about the languages used – or not – within sessions, mindful of the power of language and clients' attachment to their different languages. Some clients will actively want to speak in one language and not in another language.

Implication for Policy

- Counselling and Psychotherapy services to provide linguistically sensitive supervision sessions, run by appropriately trained supervisors.

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Tables

Table 1. Language profiles of participants

L1b or LX	Number (%) of respondents with L1b or LX	Number (%) of respondents with L1b and LX
L1b	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%)

Table 2. Interviewee profiles

Alias	Age	L1	Age acquired English	Therapy country	Therapy provider	Main therapy language	Interview language (modality)
Alicia	30+	Spanish*	5	Spain	Private	Spanish* (L1)	English
Marcela	30+	Spanish*	15	UK	Private	English (L2)	English (Skype)
Elena	20+	Italian	3	UK	Private	English (L2)	English (Skype)
Nabeela	30+	Sinhalese & Tamil	5	UK	Public	English (L2)	English
Juliette	40+	French	11	UK	Private	French (L1)	French (Skype)

* Latin American variety

Table 3. Negotiating language options for therapy

Theme	Count
Two shared languages: agreeing main language and switching	7
Two understood languages or dialects: allowing a mismatch	2
One shared language: confirming adequacy for therapy	3
Code-switching to non-shared languages	1
Total responses	**13**

Table 4. Explanations for not negotiating language options

Theme	Count
Unnecessary	21
No choices to discuss	6
Not consulted	4
Total responses	**31**

Table 5. Interview themes

Theme	Participants
No discussion (language match)	Juliette
Technical discussions	Alicia, Marcela, Elena & Nabeela
(Re)negotiating upon consideration of language processes	Elena

Biographies

Dr Louise Rolland obtained her PhD in 2019 from Birkbeck, University of London, where she is now an Associate Research Fellow. She studied how multilingual clients use their languages in psychotherapy, with implications for processing emotion and accessing plural identities. She lectures on bilingualism and has taught English and French.

Dr Beverley Costa is a counsellor, psychotherapist and supervisor, Senior Practitioner Fellow at Birkbeck, University of London and founder of the multi-ethnic counselling service Mothertongue (2000–2018), the Mental Health Interpreting Service, the Pásalo Project and Colleagues Across Borders.

Dr Jean-Marc Dewaele is Professor of Applied Linguistics and Multilingualism. He investigates individual differences in Second Language Acquisition and Multilingualism. He is former president of the *International Association of Multilingualism* and the *European Second Language Association* and is General Editor of the *Journal of Multilingual and Multicultural Development*.

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