Unveiling the experience of bilingual child and adolescent psychotherapists working in their second language: An interpretative phenomenological analysis

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I remember speaking in tongues since I was twelve,

Always wondering whether I was mad or enlightened—

Either, or

I remember things in English or in Spanish

English for politics, Spanish for love

English for praxis, Spanish for theory

English for survival, Spanish for laughter

English for time, Spanish for space

English for art, Spanish for literature

Guillermo Gomez-Pena (1991)

Abstract

This study explores the lived experiences of bilingual child and adolescent psychotherapists providing psychotherapy in their second language, especially with monolingual patients. In this context, the word "bilingual" refers to a person who has reached a proficient level in a second language in late adolescence or later. Data was collected through semi-structured interviews with 6 bilingual child and adolescent psychotherapists from different countries, with clinical experience ranging from trainee to highly experienced (approximately over 15 years of qualified work). The data was analysed using interpretative phenomenological analysis (IPA). From the data analysis, 4 group experiential themes emerged across participants: navigating cultural and linguistic challenges in therapy; the impact of therapist's foreignness into the transference; coming from another country: the painful journey of immigrant child and adolescent psychotherapists; therapist sense of self: where do I belong? The main results of the research evidence that language-related challenges might have an impact on the transference relationship, as patients can project into the psychotherapist's accent and culture. However, bilingual child and adolescent psychotherapists become more competent and confident as they conduct therapy in their second language and use the tool of transference to overcome some language-related challenges in the therapy over time. The results also show that being an immigrant child and adolescent psychotherapist can have an impact on the transference and on the own identity of participants, who need to navigate across two different languages and cultures. It is argued that, due to the increase in bilingual child and adolescent psychotherapists and bilingual psychotherapists in general, more emphasis should be placed on encouraging a dialogue about bilingualism and the difficulties it may bring to the transference.

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CHAPTER 1

Introduction

The levels of migration have increased over the past five decades (https://worldmigrationreport.iom.int/wmr-2022-interactive/). It is currently quite an important phenomenon in our society. People may choose to immigrate for a variety of reasons, such as employment opportunities, to escape a violent conflict, environmental factors, for educational purposes, or to reunite with family. The process of moving from one country to another generates a complex and multifaceted experience that has long-lasting effects on an individual's sense of self. Leaving one's home often involves giving up familiar aspects of everyday life, including food, music, customs, and language. In the new country, there may be unfamiliar cuisine, songs, politics, festivals, heroes, history, and landscapes. However, opportunities for personal growth and transformation can be found amidst these changes. One can discover new ways of expressing oneself and may encounter diverse role models, cultural norms, and values (Akhtar, 1999).

When I first moved to the UK, I found it difficult to leave my culture and language behind and adapt to the new. I was also very much concerned about whether I would be able to effectively conduct therapy in English, and worried about not being able to understand others and, conversely, make myself understood. I remember being exhausted after a full day of work, finding it difficult to continue to hear the English language, and just needing to go back to my mother tongue. I felt a sense of loss, loneliness, and separation. However, these feelings changed over time, the English language and culture grew inside me, and I now feel much less split and like I have integrated the two identities. Also, working in English got better with time:

starting the training in child and adolescent psychotherapy was really important for me and for my identity.

It was not easy to choose a topic for my research, but I remember beginning to think about this theme at the beginning of my second year. After a long training day, I went out with some of my fellow trainees, and one of us described their experience of having an analyst from their same birth country, sharing the same mother tongue, but, they said, during sessions they would use their second language. I found this very interesting, and the more I thought about it, the more questions arose. I thought about the reason why I chose an English analyst and not an analyst who spoke my mother tongue. Had I wanted to achieve some separation from my Italian identity? I continued to think about this topic over the following months. I was then given the opportunity to work in my mother tongue, and all my expectations were destroyed. I had assumed that working in Italian would have been ideal; that I would immediately connect with my patient as we shared the mother tongue and culture. However, it was not easy, and I struggled with working in Italian, finding it difficult to put down emotional boundaries, and struggling to use psychoanalytic language in Italian. After this experience, I was sure that my research needed to focus on exploring the experiences of bilingual child and adolescent psychotherapists working in their second language. In this context, the word "bilingual" refers to a person who has reached a proficient level in a second language in late adolescence or later.

I conducted a bibliographic search to find the most appropriate literature for my topic. Coming across Walsh's 2014 paper "The bilingual therapist and transference to language: Language use in therapy and its relationship to object relational context" gave me more insight into my topic. However, when working on my literature review, I realised that the majority of the studies were focused on the experiences of bilingual therapists with bilingual patients, and the

switching of languages during sessions. It was hard to find studies or articles on therapists working in their second language with monolingual patients belonging to the dominant culture, especially with child patients.

As my aim was to investigate the emotional experience of bilingual child and adolescent psychotherapists, the IPA method seemed the best choice—I will explore this further in the Methodology chapter, where I will also explain the design of each part of the research project. This chapter includes a paragraph on reflexivity on my role as a researcher, where I reflect on the reason I chose this topic and some of the assumptions I had that created some issues.

In the Findings and Discussion chapters, I will give an overview of the data that I gathered. It took me some time to establish a flow in the analysis of the interviews: immersing myself in the material was not always easy, and I found it especially difficult to write up the experiential statements and find connections between them. I felt stressed, as I wanted to make sure I captured the experiences of bilingual child and adolescent psychotherapists to the best of my abilities.

The entire process involved a lot of trial and error, but what fascinated me was the realisation that, each time I revisited the material, I may uncover something new or have a different perspective. The data analysis shed some light on participants' experiences of working in their second language—especially with monolingual patients—and on child and adolescent psychotherapists' emotional experiences of being immigrants, how language-related challenges were managed, and experiences of the self across two languages, as well as the transference relationship.

In the Discussion chapter, I make links with the existing literature and discuss how my study fits with the existing body of knowledge, while highlighting the gaps that I believe my research addresses. I will also reflect on the limitations of my study, and suggest possible future research. It also includes a paragraph in which I reflect on the double role of being both the researcher of the study as well as a bilingual child and adolescent psychotherapist, just like the participants. In the Conclusions chapter, I summarise the key findings and how I believe that the data answers my research question and aims.

CHAPTER 2

Literature Review

Introduction

This narrative literature review aims to outline important works and studies that shed light on bilingualism in psychotherapy and psychoanalysis and to highlight possible existing gaps in the literature. It will begin with a description of the method by which it has been conducted. It will explore how language develops from the start of life, and examine the role that language plays for psychologists and psychoanalysts. This will be followed by a summary of developments in psychoanalytic theory on bilingualism and how the concept of 'mother tongue' is understood in the literature, focusing on bilingual writers' reflections, clinical vignettes, therapists' first-hand accounts and autobiographical research, as well as language dynamics in therapy, with special focus on transference. It will also explore how culture is embedded in language, and the role of the immigrant therapist. Benefits and challenges of working in a second language will be suggested. The literature will also offer a synthesis of qualitative studies carried out to examine the experience of bilingual psychotherapists working in their second language.

The whole study aims to explore the experiences of bilingual child and adolescent psychotherapists providing psychotherapy in their second language. Given that using a second language often correlates with being an immigrant and thus not part of the dominant cultural group, the study is particularly interested in examining the emotions and feelings of these therapists from minority cultures working with monolingual patients from the dominant culture. The rationale for the study is that there is a notable gap in research on therapists who work in their second language with monolingual patients from the dominant culture, especially in the context of child and adolescent psychotherapy. In addition, it would significantly

enhance our understanding in this under-researched area. Furthermore, given the increasing prevalence of immigration, understanding these experiences can offer valuable insights for clinical practice. This knowledge is also crucial for supervisors who support bilingual psychotherapists in their professional development.

Method

A bibliographic search, focusing on published articles, books, and papers, was conducted to identify the most pertinent sources to the research question: What is the experience of bilingual child and adolescent psychotherapists working in their second language? Searches were conducted across a range of research databases, including PsychInfo, PsychArticles, the PEP Archive, and the Psychology & Behavioral Sciences Collection, which are among the most comprehensive databases for psychology and related disciplines. The following keywords were searched: "psychotherap*"; "psychoanal*"; "second language", and "bilingual therap*". Papers were sourced using Boolean operators "AND" and "OR". Double quotation marks and * were used when searching for plurals. In addition, searches were also carried out using Google Scholar and the Association of Child Psychotherapy (ACP) database. Other studies were identified via reference lists from related studies. The results of the search suggest, to the best of my knowledge, that no study has been conducted within the child psychotherapy discipline on the specific topic of the present study. However, the database searches produced a number of interesting results on this topic in other disciplines. A large number of articles treated the subject of bilingualism and the phenomenon of switching language in therapy. However, I will not report on these studies, as they fall outside of the interests of this study.

Language acquisition and what language represents for psychoanalysts and psychologists

I believe it is important to begin by briefly covering the development of language as such, as language plays a crucial role in the therapeutic process and in our relations with others. As the

literature on this topic is really extensive, and since it is not the aim of this review to cover all the literature on language development, I will outline the literature that I believe to be most pertinent to this research project.

Language develops as a result of the close relationship between mother and child; language enables us to express our internal world, and this encourages us to view language as an object-relational function, which entails the idea that infants form mental representations of themselves in relation to others and that these internal images significantly influence interpersonal relationships later in life (Oliva, 2017). Steiner (1999) has described how mother–baby communication begins from the very first day of the baby's life, through the mother's touch, eyes, and voice responding to the baby's signals and needs. The mother's care for, and interaction with, the baby shapes its psychological experience, which is introjected as either good or bad. A content and nourished baby feels loved, which contributes to a good experience. However, when the baby is hungry, frustrated, or uncomfortable, he will project his negative feelings through crying for the mother. Through this communication, the baby expresses his needs so that the mother can respond accordingly. By attending to the baby's physical needs with care, the mother is essentially expressing her love for her child. Mothers talk to their babies instinctively, knowing that their voice provides 'holding' of the baby. By the end of the first year, in normal development, the baby will have internalised this experience of having a caring and attentive mother who is attuned to his needs. As the baby grows and develops, his babbling evolves into more complex sounds that resemble the mother's words. This development is fuelled by the baby's innate desire for connection, and it is influenced by the experience of hearing his mother speak to him directly (Steiner, 1999).

The mother provides support and containment that nurtures the child's ability. This "maternal reverie" postulated by Bion (1962), involves understanding the newborn's feelings and needs

giving them meaning. It is the function of the mother-container: the mother will contain the anxiety, the intolerable and fragmentary thoughts and emotions of her baby and she will resist being overwhelmed by them, giving them back to the baby in a more tolerable and acceptable shape, in a “digested” form. The maternal reverie gives the child the possibility to develop, through contact with the outside, an emotional life, mental activities, cognitive and motor skills (Waddell, 2005). A child who has had this experience will gain a meaning that will allow him to develop a capacity to symbolise and verbalise their experiences and reflect upon mental states (2005). However, for Bion (1962) negative experiences and repeated obstacles in the communication, will suggest to the baby the “persecutory presence of bad things inside him” (2005) possibly affecting his personality and development of the link-making function.

Urwin (2002), in her work with autistic children, agreed with what Bion suggested. She noticed that her patients with issues related to language and communication had a background of deprivation and trauma. She observed that her patients’ parents’ own tragedies hindered their ability to contain their children's anxieties, disrupting link-making and contributing to a "nameless dread," as described by Bion, resulting in delayed or inhibited speech. Helping the parents discuss their own situations improved their ability to respond to their children and reduced some of their own projections.

Overall, language development is seen as emerging from the containment relationship, where the caregiver's attunement and reflective capacity provide the scaffolding for the child's linguistic and cognitive growth. The ability to name and articulate feelings and thoughts is directly linked to the quality of early containment experiences, which foster a sense of security and coherence.

Hobson (2002) in his book, ‘The cradle of thought, exploring the origins of thinking’, writes that thinking originates from interpersonal interactions, with social engagement and emotional

connectedness forming the foundation for thought. He describes how the nature of social-emotional interactions between mothers and their infants evolves as the infants grow. These interactions serve as a crucial foundation for the emergence of thinking. A significant milestone occurs in the second half of the infants' first year when these interactions between mothers and infants start to involve objects in their environment. This marks the development of the 'relatedness triangle', where the infant 'starts to relate to someone else's relatedness to world' (p. 92). This new way of interacting enables infants to move beyond their own perspective and recognise that the world has meaning for others, and that this meaning can influence their own understanding. Children observe, participate in, and identify with adults' actions, gradually adopting the 'position of the other' (p. 108). Through these experiences within the relatedness triangle, children, by their second year, learn to adopt the perspective of others towards themselves, recognizing their own outlook as a distinct perspective. Hobson asserts that this level of self-awareness, essential for symbolic communication and imagination, is achievable only because the child identifies with others' attitudes towards their own attitudes and actions, becoming 'self-aware through others' (p. 106). Overall, for Hobson (2002), the development of thought resembles a dance led by the adult. In this dance-like exchange, the parent and child form the foundation for thought by engaging in and responding to each other's emotional interactions.

I believe it is important also to mention Melanie Klein as she emphasizes the fundamental importance of the first object relation for the baby - the relationship with the breast and the mother. She concludes that if this primary relationship, when introjected, poses stable roots in the ego, this creates the basic preconditions for satisfactory development. 'Splitting' is a very important concept for Klein, as she writes in, 'notes on schizoid mechanisms' (1946), the splitting results in the disjunction and the separation of hatred, by love. The relationship with the first object implies introjection and projection, so the object-relations are molded from the

beginning by the interplay between introjection and projection, between objects and between internal and external objects and situations (1946). Splitting is a defence mechanism that allows integration. Indeed, this integration, is the basis of her theories. Klein believes, in fact, that the ego, at birth, is immature and unorganized and that it seeks integration. Having two objects - one good and one bad - is vital for the ego can overcome in order to overcome the fear of persecution. Self-preservation for the child in the early childhood depends, in fact, on their trust in a 'good' mother. By separating the good and bad aspects, the child and he retains his faith in a good object, which is an essential condition for sustaining life and, in fact, without which, the child would remain exposed to a hostile world in which he would fear being destroyed. Klein (1946) writes: "*The process of splitting off parts of the self and projecting them into objects are thus of vital importance for normal development as well as for normal object-relations."* (p. 9). This first object relation for the baby is crucial for satisfactory development, for identity formation and the development of language.

The moment that a person acquires the ability to speak represents a crucial milestone in their psychological growth, marking the end of infancy and the beginning of childhood, when language, as an organised system of verbal expressions created and maintained by culture, becomes accessible to each individual (Greenson, 1950).

In 1992, Harris conducted a thorough examination of a 20-minute conversation between a mother and her four-year-old child. The study highlights the significant role that language plays in shaping a child's understanding of their identity and desires. The author specifically examines how the child's use of themselves in relation to a transitional object evolves through their speech and interactions with their mother. This process continues as the child grows and engages in dialectics beyond their primary objects (Pérez-Foster, 1996). Other individuals in

the child's cultural community will take on the roles of mediators and verbal negotiators, shaping and deepening the language that the child is able to use to describe the external and internal aspects of their experiences (Stern, 1985; Wilson and Weinstein, 1990). This expansion of word-meanings is influenced by a combination of developmental milestones, diverse social environments, and meaningful exchanges with significant figures (Wilson and Weinstein, 1990; Pérez-Foster, 1996).

According to Vygotsky (1981), whose central idea is that the development of the psyche is guided and influenced by the social context of each individual, the primary purpose of speech is social communication. Speech is seen as one of the 'tools' that culture and the environment make available to the child, and through which he develops. Vygotsky was among the first to argue that all higher mental functions, internal ideation, and self-related thoughts are based on social interactions with others (Pérez-Foster, 1996). In his book *Thought and language* (1934/1962), Vygotsky explored the relationship between language-development and thought, highlighting the significance of both silent inner speech and oral language in the development of mental concepts and cognitive awareness (Oliva, 2017). Similarly, Whorf (1956) and Vygotsky (1978) proposed that language can shape an individual's worldview and influence their experiences. They argued that language can impact thought-processes, memory, perception, and actions (Whorf, 1956; Vygotsky, 1978).

In psychoanalytic theory, Freud (1938) gave language a pivotal role for the individual internal life and development, describing language as an intermediate between the conscious and unconscious processes (Connolly, 2002) that connects the materials in the ego with the memory traces of visual and auditory perceptions. This connection can make ideas and intellectual processes conscious (Loewenstein, 1956). Other psychoanalysts, such as Loewenstein, have

described how language transforms how we make sense of our experiences (Tummala-Narra, 2016). Lacan (1981), the French psychoanalyst, took this concept further by stating that the "unconscious is structured like a language" (p. 20). In his view, the meanings of language are shaped through relationships between signifiers (sounds or images) and signified (concepts), as well as differences among signifiers. This perspective shifts language from an internal entity to an intersubjective one that is rooted in culture (Connolly, 2002). Lacan argues further that a person's subjectivity is formed through interactions with signifiers within the context of language, proposing that language serves as a means for the unconscious to reveal itself, often manifesting through misunderstandings, confusions, slips of the tongue, and absent-mindedness (Lacan, 1953).

In summary, language is understood to be formed through the strong and intimate bond between a caregiver and their child, allowing us to communicate our thoughts and emotions, while also playing a vital role in our interactions and connections with others.

Bilingualism in psychoanalysis

Generally, bilingualism is defined as the ability to use two languages for communication in everyday life. Bilingualism has always been present in psychoanalysis; however, for many years it remained an unexplored topic (Frie, 2013). For instance, Freud analysed patients in English, which was his second language, and he also had patients for whom German was their second language (Lijtmaer, 1999). The first psychoanalytic case study, that of Anna O. (Breuer and Freud 1895), demonstrates the role of various languages in the patient’s changing psychological experience. As Anna O. stopped using German—her mother tongue—she would instead conduct her analysis in English, her and Freud’s second language. In his work with the Wolf Man, Freud (1918) reported that the patient used his difficulties with his second language

as a defence, and in Freud's treatment with Dora (1905) he explained that his switching languages to French was a defence against the complex emotions that Dora stirred up in him (Lijtmaer, 1999). In a letter to his nephew, Freud was quite honest in describing some of his frustrations at conducting therapy in his second language (Gay, 1988).

In 1916, psychoanalyst Szandor Ferenczi wrote the paper "On obscene words", which noted that when patients spoke obscenities in their native language, it elicited a stronger emotional response as compared to when they were spoken in their second language (as cited in Amati-Mehler, Argentieri, & Canestri, 1990). His theory was that patients who refrained from using obscenities in their native language were creating a distance from their infantile sexuality, which greatly impacted the analysis. This marked the first time such observations were made concerning the use and impact of language in therapy. Ferenczi's findings highlighted how individuals have varying emotional reactions to words based on the language in which they are spoken, while also raising the question of whether the unconscious is linked to a specific language (Skulic, 2007).

In the 1950s, psychoanalysts began writing about bilingualism, its impact on psychoanalytic treatment, and the challenges they faced while treating patients who spoke more than one language (Buxbaum, 1949; Greenson, 1950; Krapf, 1955). Buxbaum focused on the roles of the ego and superego in language acquisition and use when working with English and German-speaking clients. She proposed that patients may choose to speak in a certain language to distance themselves from the emotional content that is addressed during therapy. She believed there was a connection between the language used in therapy and the control of the superego and memory repression. Greenson (1950) explored how language would impact the therapeutic process. In his study of a German-English bilingual woman, he introduced the idea of different

self-representations based on language. His patient stated that “[in] German I am a scared, dirty child; in English I am a nervous, refined woman" (p.18), highlighting how language can influence one's self-perception and presentation to others. In 1955, Kraph proposed that a multilingual patient's decision to speak a specific language during analysis with an analyst who is also fluent in multiple languages, is often driven by their desire to alleviate anxiety.

Since the 1970s, there have been many studies on themes pertaining to bilingualism and its effects on the therapeutic relationship (Lijtmaer, 1999), such as switching language in therapy (Marcos et al., 1977); language barriers (Marcos, 1976), and language independence (Marcos & Alpert, 1976), which refers to the capacity to have two independent language systems with connected object-relations. Javier (1989), talking about language independence, describes that the bilingual individual has acquired and maintains the use of two separate linguistic systems, “each with its own lexical, syntactical, phonemic, semantic and ideational components” (Javier, 1989, p. 88).

A few years later, Pérez-Foster (1992) explored the link between various language systems and distinct self-perceptions, based on Greenson's (1950) perspective, and found that bilingual individuals have a dual framework and use two sets of verbal symbols to organise their world. As a result, they are able to process thoughts, emotions, and experiences in two distinct manners that may not be accessible to those with a monolingual structure (Pérez-Foster, 1996).

Mother tongue and the use of second language in therapy

When discussing bilingualism, it is important to consider the mother tongue, also referred to as the language in which a child first learns to speak and think (Amati-Mehler et al., 1990). However, this definition may be problematic for individuals who learn multiple languages as infants. Unfortunately, given the word-limit of this dissertation, I will not explore what is

considered a mother tongue for those who learn several languages from a very young age. The concept of a mother tongue has received a lot of attention in psychoanalysis (Rosenblum, SM, 2011); therefore, I believe it is necessary to briefly examine how the concept of the mother tongue (or first language) has been approached.

According to Krapf (1955), the mother tongue was considered the language of the id, as it acted as an "intrapsychic registry" (p. 344) of sounds and words that could potentially evoke a range of experiences, wishes, conflicts, and memories from early infancy (Buxbaum, 1949; Krapf, 1955; Greenson, 1950). Contemporary research in psychoanalysis confirms that the mother tongue serves as both a code and a symbol for early life's developmental and relational challenges (Javier, 1989). Both Buxbaum (1949) and Krapf (1955) believed that how an individual uses their mother tongue and learns to speak it is heavily influenced by their relationship with their primary caregivers.

In addition, Canestri and Reppen (2000) referenced studies on how non-verbal and auditory elements of language play a role in early development, specifically the calming effect of a mother's voice on an infant. They found that disruptions in the mother–child relationship could affect the child's acquisition of their native language in a multilingual setting. This was supported by Pérez-Foster (1992), who proposed that a person's understanding of and attachment to a particular word or language might be influenced by their early relationships during the learning process.

Buxbaum (1949), Krapf (1955), and Greenson (1950) described the mother tongue as the language of the unconscious, the place where strong emotions, core conflicts, and vivid fantasies reside. Regarding the second language, which is typically learned at a later

developmental period, Buxbaum and Greenson (1949; 1950) both proposed that conducting the therapy in the patient's second language may limit their ability to access certain aspects of their inner experience during the psychoanalytic process. Buxbaum (1949) described the case of a German woman who moved to the US as a teenager and was fluent in both English and German, while English was the language used in therapy. The patient's primary focus and anxiety revolved around male sexuality. However, when she used German slang from her school days, she was able to unlock repressed memories from her childhood, which revealed unresolved sexual conflicts. Buxbaum argued that bilingual patients may use their second language to distance themselves from painful psychic experiences, avoiding the language associated with their key fantasies and memories. She believed that working in the mother tongue makes it possible to awaken the past and bring certain unconscious emotions to consciousness, as talking about some experiences in the language in which they happened makes them real, while verbalising them in another language makes them unreal and risks losing the intensity of associated emotions. She thinks that a second language can be the language of repression and may be used as a defence mechanism for painful experiences.

A year later, Greenson (1950) described the analytic treatment of another bilingual German/English patient. In the analysis, the patient initially refused to speak German, saying "I have the feeling that talking in German I shall have to remember something I want to forget" (p. 19). She expressed a fear of saying obscene words in German, explaining "that they were much easier to say and cleaner in English" (p. 19). Greenson explained that, for this patient, German represented early childhood conflicts while English served as a defence mechanism against these unresolved issues. As a treatment technique, Greenson incorporated the mother tongue to break through the defences and access repressed emotions related to the patient's early experiences. These papers highlight how language can serve as both an avenue for

releasing unconscious material and a defensive tool against the therapeutic process. Many years later, Walsh (2014) wrote that “a primary language has the potential to be both a language of intimacy and connection as well of distance and defense” (p. 67).

While the second language was initially viewed as a tool for repressing difficult experiences, researchers would also observe its potential for creating a more harmonious and transformative sense of self (Skulic, 2007). Greenson (1950) found that the second language allowed a possibility of the "establishment of a new self-portrait" (p. 20), by further suppressing distressing thoughts and emotions. Additionally, Buxbaum (1949) argued that the use of a second language served not only as an extra defence mechanism against distressing thoughts and fantasies, but also gave individuals a linguistic outlet through which to process traumatic material. Buxbaum (1949) reported: “A second language might be compared to the singing of silent children; both free the words of the emotional charge which burdens and inhibits the use of the native tongue. With the help of the new language, the superego was circumvented and its efficacy was weakened to some extent” (p. 286). Some years later, Movahedi (1996) said, “…a second language may at times provide the only space where the analyst can meet the patient out of reach of certain personal and cultural ghosts” (p. 837; p. 860). In addition, learning a second language can provide a fresh perspective and allow for the exploration of different values and social dynamics that may not be possible in one's native tongue (La Roche, 1999; Pérez-Foster, 1998).

The above literature addresses the role bilingualism plays in psychotherapy for patients only. Further, the majority of the literature on this topic dates back to the 1950s, with only a few more recent references. The findings are even more scarce when the focus is shifted onto the bilingual psychotherapist. Indeed, the role of the mother tongue, the second language, and the

impact of different language systems on the bilingual psychotherapist have not been fully addressed (Walsh, 2014). Indeed, Walsh holds that we should expand our understanding of the effects of the mother tongue on early object-relations for the patient by considering not only the patient, but also the therapist. She thought that incorporating the concept of multiple language-based selves into the knowledge of multiple selves would provide a deeper understanding of the constantly evolving therapeutic relationship between therapist and patient. By recognising which language system is being used and its impact on our emotions, projections, defences, and conflicts, we can gain insight into the transferential and countertransferential dynamics within the therapy. She described how therapists with bilingual abilities are uniquely able to explore the "transference to language" (p. 60), that is, the specific influences that different languages have on individuals. This shift from a broad viewpoint to a more specific one acknowledges the significance of each person's linguistic self and object relations while utilising a particular language in therapy.

Regarding the bilingual therapist's use of the mother tongue, a recent study conducted by Connell et al. (2016) reported that, if a psychotherapist is trained in their second language, they often feel more comfortable conducting therapy in that language. Akhtar (2006) reported that the bilingual analyst may occasionally feel the urge to use their mother tongue, even if the patient cannot understand it. He believes that it is important for the analyst to reflect on the triggering factors behind this desire through self-analysis and to consider what in the patient's communication prompted this response and whether it touched on a personal aspect for them.

The immigrant therapist

When the topic of bilingualism is discussed, it also inevitably includes immigration. For this reason, I will briefly mention this topic. Immigration is commonly seen as the process of moving to a new country for permanent residency, whether by choice or by force. It involves

leaving one's home and facing significant losses. However, amidst these losses, there is also the potential for personal growth and transformation. With the move comes new avenues for self-expression, different role models, norms and values (Akthar, 1995). The act of immigration often means moving from an “average expectable environment” (Hartman, 1950) to a strange and unpredictable one (Garza-Guerrero, 1974). This adjustment involves not only changes in one’s personal identity, but also to group identities, such as ethnicity and nationality, given the impact of social and cultural adjustments of immigration (Horenczyk 2000). Further, it is often necessary for the immigrant to acquire proficiency in a second language.

While the history of bilingualism and immigration does include psychoanalysis (Amati-Mehler et al., 1993; Clauss, 1998), the subject received scant attention in psychoanalytic theory for many years. It was only in the 1930s, following the rise of the Nazi regime, that psychoanalysts began to explore the topics of bilingualism and immigration, due to many Jewish analysts emigrating then (Amati-Mehler et al., 1990; Foster, 1992). Akhtar (2006) attributes this lack of interest to two possible factors. Firstly, many of these analysts were exiles who had experienced traumatic events in their home countries and were thus motivated to distance themselves from their origins. Secondly, they may have focused on adapting to their new cultural environment and neglected the psychological aspects of being an immigrant and being bilingual.

When a person moves to a new country, this individual becomes part of a new culture; this process is usually called ‘acculturation’. Acculturation can be seen as the interaction between the attitudes and characteristics of immigrants and the response of the receiving society, influenced by the specific circumstances of the immigrant group within that new society (Bouhris et al. 1997; Mana et al. 2009; Phinney et al. 2001). This process affects both cultures,

but members of the minority culture typically experience a greater need for adaptation, including changes in behaviours, attitudes, and values.

Originally, acculturation was thought to be a one-way process, where the minority culture gives up their traditional beliefs, customs, and behaviours in order to adopt those of the majority culture (Garcia and Lega, 1979; Ryder et al., 2000). However, this idea has been revised into a bi-dimensional model (Berry, 1980; 1983; Birman, 1994; Sodowsky et al., 1991). According to bi-dimensional theorists, acculturation involves both assimilation into the majority culture and retention of the minority culture, and these two processes are independent from each other (Berry, 1997; 2006). Berry's model outlines four possible outcomes of these dimensions: integration of the two cultures, rejection of both, or acceptance of one while rejecting the other (integration, separation, marginalisation, assimilation). Research suggests that integration of the two cultures is the approach that is most beneficial for overall well-being as compared to the other three strategies (Mana et al., 2009; Phinney et al., 2001).

The therapist's experience with immigration and acculturation plays a crucial role in shaping their sense of self (Akhtar, 1999) and how they interact with their patients in therapy. Indeed, for bilingual immigrants, the experience of immigration can be distressing and traumatic. Some authors (Hill, 2008; Pérez-Foster, 1998) have observed that new immigrants may initially view their original language and culture as entirely positive while seeing the host country and language as entirely negative, or vice versa. In these situations, when the therapy is with bilingual patients and therapists, switching between languages can allow the individual to acknowledge and integrate both aspects (Kokaliari et al., 2013).

Furthermore, immigrant therapists can experience themselves as outsiders in the new country (Kissil et al., 2013). The feeling of alienation is heightened for individuals who do not speak English as their first language, do not fit the traditional image of a person born in the new country, or come from a culture significantly different from mainstream Western culture (Isaacson, 2002; Mittal & Weiling, 2006). Despite this sense of otherness, it can actually help immigrant therapists to connect with patients who have also felt marginalised (Isaacson, 2002; Tang & Gardner, 1999; Tosone, 2005). This may include ethnic and racial minority patients, those critical of their own culture, and immigrant patients. It can be emotionally demanding for immigrant therapists to feel different, and may lead to doubts about their ability to effectively help others (Isaacson, 2002; Mittal & Weiling, 2006). However, by embracing this experience of otherness instead of letting it hinder them, immigrant therapists can use it to enhance their therapeutic skills (Kissil et al., 2013).

Both Verdinelli (2006) and Akhtar (2006) emphasise the significance of self-awareness for bilingual therapists when working cross-culturally. This allows for better management of countertransferential enactments that could potentially harm the therapeutic relationship. Additionally, Akhtar (2006) coins the term "nostalgic collusion" (p. 21) to describe a clinical scenario where the patient's defensive mourning of their idealised culture was not effectively addressed, potentially due to the therapist's own unresolved grief over their cultural history.

Similarly, Walsh (2014) talks about her experience of being an immigrant therapist and working with immigrants in Israel. She talks about her immigrant status and associated feelings of loss and dislocation as well as the risk of identification with the immigrant patient’s experience. Surprisingly, she discovered that when working in her native language—English—she was less able to fully address transference issues. She came to the realisation that her English therapeutic self-retained a sense of identity from before her immigration, which could

unconsciously collude with her immigrant patients to avoid confronting difficult emotions. By not going deeper into these emotions, she overlooked uncomfortable feelings that arose in the transference, such as competition and anger. The above authors all agree on the importance of being aware of these dynamics in the work with patients.

Culture embedded in the language

In a therapeutic setting, our communication is not limited to just words. Our language also reveals aspects of our cultures, personal histories and individual identities in ways that we may not be aware of (Frie, 2011). This is particularly important to consider as languages are deeply ingrained in our cultures (Bourdieu, 1990), bilingual work involves working across cultures.

Culture has a profound impact on our actions, thoughts, and emotions. It is deeply ingrained in every aspect of human life. Psychotherapists, psychoanalysts, and their patients are all undoubtedly influenced by their cultural backgrounds. Frie (2011), assuming a hermeneutic approach (as suggested by Gadamer (1975) and Taylor (1989), suggested that our self-perception, relationships with others, and perception of the world are all shaped by culture. When we view culture as just one of many developmental contexts, we fail to acknowledge the extent to which we are all entrenched in cultures, histories, and languages that are not under our control.

In her 1998 work, Pérez-Foster discusses the concept of cultural countertransference, which refers to the difficulties of working with patients who come from a different culture, race, or social class than our own. She describes this as interacting with an "ethnic stranger" (p. 155).

In conclusion, a language difference between the therapist and patient can bring attention to cultural differences and positioning, potentially impacting power dynamics in therapy. Both

parties may hold unconscious cultural stereotypes, which the therapist could mistakenly attribute to the patient's transference. Additionally, when working in a second language, therapists may struggle with their own experiences of being part of a minority culture, potentially leading them to show excessive interest in the patient's culture and language. It is important for bilingual therapists to reflect on their own experiences with language, culture, immigration, and working in a second language to effectively navigate these complexities in therapy (Antinucci, 2004; Verdinelli, 2006; Skulic, 2007).

Transference relationship and countertransference in bilingual psychotherapy

The transference and countertransference in bilingual psychotherapy have mainly been studied in the context of the bilingualism of both psychotherapist and patient, with the main focus being on the importance of switching languages in therapy. As these dynamics are less relevant for my research, I will focus on the transference dynamics present when the psychotherapist is bilingual and works in their second language.

The linguistic and cultural backgrounds of the client and therapist have a significant impact on the transference (Kokaliari et al., 2013). When there is a difference in background and language between the therapist and patient, it can result in various transference reactions, such as over compliance, hostility, or mistrust towards the therapist (Akhtar, 1999; Comas-Díaz & Jacobsen, 1991; Lijtmaer, 1999; Roland, 1996). These reactions may be displayed through behaviours like lying, passivity, ambivalence, withholding information, being guarded, or avoiding important treatment topics. Differences in class, socioeconomic status, and education level between therapist and patient may cause the patient to feel undervalued or powerless and fearful of rejection or misunderstanding (La Roche, 1999). Similarly, when the therapist belongs to a minority group while the patient is part of the dominant culture, there is the potential that the therapist is seen as exotic or overly powerful (Kokaliari et al., 2013).

However, some patients from the dominant culture may also have reservations towards bilingual therapists who speak a different language than their own. This can lead to devaluation or disqualification of the therapist, due to a perceived lack of language fluency or the fear that they will be ineffective in providing services (Comas-Díaz & Jacobsen, 1991; Lijtmaer, 1999).

Cultural factors also play a role in shaping a therapists' countertransference. They bring their own conflicting feelings, and past experiences from their country of origin, as well as the possibility of higher status in the new country. This can sometimes lead to guilt for having more privilege than their patients, causing them to overcompensate by being overly involved or accommodating (Pérez-Foster, 1998).

It is important that therapists who are not proficient in the patient's language are aware of how their linguistic abilities may impact their interactions with the patient. This can often lead to mixed emotions, such as feelings of guilt and aggression towards the patient, as they struggle to maintain a sense of control, belonging, and integration (Kitron, 1992). This can also result in frustration as clinicians have to put in extra effort to communicate effectively. Additionally, there may be a sense of shame or inadequacy if patients need the therapist to repeat interpretations or if the accent hinders the therapeutic process. Unfortunately, these issues may cause therapists to become more focused on their own language difficulties rather than fully attending to the patient's emotions and verbalisations. This may all contribute to resistance on the part of the patient (Kitron, 1992). Furthermore, bilingual proficiency plays a role in the timing of interpretations—spending more time formulating interpretations means less time actively listening to and addressing transference dynamics in therapy sessions. Spending more time crafting translations means less time available for understanding and addressing transference issues within the patient. Overall, these challenges can prompt therapists to take a more guarded approach in treatment (Lijtmaer, 1999).

Lijtmaer (1999) reported how, in his work with Dora, Freud (1905) resorted to using French as a protective measure against the intense emotions she stirred up in him. This serves as a reminder of how our second language can serve as a defence mechanism.

Connolly (2002) and Jiménez (2004) both stressed the significance of nonverbal communication in therapy for therapists who conduct sessions in their second language. They believed that affective attunement strengthens the therapeutic relationship. Both authors also point out that speaking multiple languages has the advantage of making one acutely conscious of language as a sensory and expressive experience, rather than solely about conveying meaning.

Jimenez (2004) also noted that the perceived foreignness of the analyst can contribute to the appearance of transference, which can lead to the emergence of repressed aspects of the psyche. Williams (1999) also emphasised how the therapist's "strangeness" plays a role in enabling individuals to gain a deeper understanding of their psychological reality and promote personal growth (p. 14).

Challenges of working in a second language

In his Freud biography, Gay (1988) revealed that Freud was open about the frustrations he faced while conducting therapy in his non-native language. In a letter to his nephew, Freud expressed concern about his English proficiency: "I am anxious about my English […] I listen and talk to Englishers 4-5 hours a day, but I will never learn their d****d language correctly" (Gay, 1988, p. 388). However, this aspect of using one's second language when conducting therapy received little attention until Flegenheimer's work in 1989. Flegenheimer proposed that the most prominent difficulties faced by therapists are understanding the patient and being understood themselves. He argued that a lack of proficiency and a deep understanding of one's second language can obstruct this process. Lijtmaer (1999), as reported above, suggested that

therapists may feel angry because they have to put in extra effort to communicate effectively, or humiliated when their patients ask them to repeat an intervention. Difficulties such as accent, slower pace, and limited language skills are also highlighted. Consequently, therapists may become hesitant when making certain interventions and instead focus on their own struggles with the language.

Akhtar (2006) reported that, when working with patients who speak a different language, an early-career therapist may struggle to understand puns, double-entendres, metaphors, and allusions. It is important for the therapist to ask about unfamiliar words or phrases, but also if there are any sudden pauses in the patient's speech. Sometimes, these pauses can reveal underlying anxieties related to the therapist's background and trigger transference-based concerns. Szekacs-Weisz (2004) described another difficulty, explaining that words may not carry the same weight or meaning in different languages, going on to explore the meaning of "love" and "hate" in Hungarian and English. Additionally, researchers have noted that certain concepts may be especially challenging to translate (Heelas, 1986; Levy, 1984; Pavlenko, 2002). However, Sprowls (2002) and Skulic (2007) reported that, as therapists gain expertise, common challenges tend to lessen.

Benefits of working in a second language

According to Grosjean (1982), having the ability to speak multiple languages can broaden one's perspective and increase sensitivity towards minority groups, as well as their linguistic difficulties. It can serve as a valuable tool for comprehending and assisting others in need. Researchers have found that being fluent in multiple languages can enhance the understanding of a client's experiences and improve communication (Gulina et al., 2018). Connolly (2002) observed that her bilingual abilities allowed for various connections and associations to be

made, providing a deeper understanding of transference–countertransference and conflicting material. This process also encouraged Connolly to focus on the sounds and rhythms of words rather than just their signified meaning, which led to a withholding of interpretations and allowing patients to regress back to their preverbal state. Amati-Mehler (2004) similarly noted that utilising multiple languages promotes diverse associations as the mind processes mental objects in different languages at once, resulting in a coherent response. She shares an example from her clinical work, where multilingualism enabled multiple meanings and narratives within the therapeutic setting. Moreover, Costa's (2010) more recent study indicates that both counsellor and patient may share the experience of loss associated with not being able to speak one's native language or losing one's country. Counsellors reported feeling a stronger connection with patients as a result, and better attuned to meanings beyond spoken words. In Ayora Talavera and Faraone's (2012) view, language barriers can become potential opportunities to enrich the dialogical experience in therapy.

Research on the experience of the therapist working in a second language

Several studies have explored bilingualism in therapy, however, the main focus has again been on the perspective of bilingual patients or on the effects of switching languages during sessions, when both therapists and patients were bilingual. In this section, the focus will be on four fairly recent studies—Connell et al., 2016; Gulina & Dobrolioubova, 2018; Medlicott et al., 2022; Nguyen, 2014—which are the most relevant to my research topic. All of the studies that I will report on below are based on work with adult patients. Unfortunately, I could not find any study with child patients. I came across one reference on Sella's (2006) Doctoral dissertation *Countertransference and empathy*, but I was unfortunately unable to find it anywhere.

Nguyen's (2014) piece is a qualitative research study exploring the experiences of non-native English psychodynamic psychotherapists conducting counselling in English. Nine

psychodynamic psychotherapists—all born outside the UK, with English as their second language—were interviewed about their work with monolingual and bilingual patients, with a focus on the therapeutic alliance. The data was analysed using interpretative phenomenological analysis (IPA). The results were reported and covered two main aspects: psychotherapists' experiences with monolingual patients, and psychotherapists' experiences with bilingual patients. The findings revealed that some monolingual patients made frequent assumptions about the therapist's background, while others tried to establish a connection with the therapist. There were also instances where stereotypical assumptions were made based on the therapist's perceived birth country. Interestingly, some monolingual patients felt more comfortable working with a therapist from a different linguistic background and saw it as an opportunity for acceptance of their own differences. Although the primary focus of this study was on linguistic issues, the role of culture was acknowledged but not explicitly studied. Ultimately, the findings highlight the importance of identification and over-identification with the therapist, in therapeutic relationships where English is not the therapist's first language. It was found that mutual identification between psychotherapist and bilingual patient was often based on shared bilingualism, but there was also evidence of over-identification being present in these relationships.

The paper “A third language in therapy: Deconstructing sameness and difference” (Connell et al., 2016) reported on recent research studies conducted by the first author, Connell, and her personal experience of being born bilingual, to then acquire a third language later in adolescence. Its main focus was on the impact of bringing awareness, in therapy, to the language difference between therapist and patient, while the background of the therapy was not specified. The studies explored the individual lived experiences of migrant psychotherapists and counsellors, specifically addressing the challenges faced when

communicating with patients using a second language. A total of five practitioners were interviewed, including the researcher herself, who was interviewed by a native English speaker. Data analysis was again conducted using IPA, revealing some key findings in the experiences of these practitioners: their anxiety relating to their differences from patients, no direct correlation was reported between their language fluency and effective communication, and how using multiple languages can create separate identities within a person. Additionally, the study highlighted the importance of the practitioners to be open about misunderstandings in order to form deeper connections with the patients, as well as the emergence of a "third language"—indicating a professional therapist identity formed through working in a second language. This concept of a third language can be utilised as a tool to navigate perceived similarities or differences in therapeutic encounters, allowing for collaboration with patients on both literal and metaphorical levels. Overall, this study helped raise practitioners' self-awareness regarding the complex emotions they may experience while working in their second language.

In their 2018 study, Gulina and Dobrolioubova aimed to achieve two main objectives. Firstly, the authors aimed to investigate the experience of bilingual therapists working in a second language. Secondly, they sought to understand the role of language in therapeutic settings. To do this, the researchers also used IPA to deeply explore the experiences of 16 bilingual therapists from different professional backgrounds, including psychoanalysts, psychotherapists, counselling psychologists, clinical psychologists, and counsellors. The results of this study showed how participants shared their challenges when conducting therapy in their non-native language, such as the creation of unique phrases and of individual speech patterns. The therapists also reflected on how their accents or pronunciation differences might affect their work with patients. Notably, participants shared both positive and negative aspects

of using a second language in therapy, discussing potential hindrances as well as benefits for successful treatment. For instance, some expressed feeling less creative when using their second language, or losing richness in interpretations, while others felt more detached from their own emotions when speaking a non-native tongue. Additionally, some expressed concerns about unfamiliar cultural factors that may impact patient transference. Moreover, the participants shared their perceptions regarding their use of language and how it relates to their personal identity. Some expressed worry about their ability to interpret symbolic material presented by patients, highlighting differences in understanding symbolism. Overall, the majority of participants believed that being proficient in English as a second language was crucial to their professional identity. Several also shared feelings of worry, discontent, and apprehension regarding this aspect of their abilities. There were no reported any differences reported in relation to their professional background.

Medlicott et al.'s (2022) study examined the experiences of bilingual therapists with English as their second language, who work with native English-speaking patients. The focus was on how therapists' bilingualism may influence power dynamics in therapy, particularly when the patient is perceived as more linguistically competent. The aim was to offer a different perspective from the commonly held belief that linguistic differences pose challenges. The sample included 6 therapists and counsellors who were interviewed and had their responses analysed through thematic analysis (Braun and Clarke, 2012). Three themes emerged, revealing how these professionals perceived their bilingualism: as an inherent vulnerability, as a tool, and as something left unspoken. The data indicated that being viewed as vulnerable due to their bilingualism often led to power struggles for these therapists. They also reported feeling patronised or diminished at times, when their diversity was used against them. However, despite these challenges, many participants believed that embracing this vulnerability could

strengthen the therapeutic bond and promote equality between therapist and patient. This highlights the importance of viewing bilingualism as a valuable tool. Interestingly, most participants felt that their diversity was not adequately recognised during their training and supervision sessions, resulting in it remaining unaddressed between them and their clients.

Conclusions

This literature review has explored the role of language and shown how language development is embedded in relationships, particularly in the very early stages of life; indeed, the bond between the child and the primary caregiver plays a vital role in the evolution of language. This first exploration of the literature gives a frame of reference when exploring the role of bilingualism in a psychotherapist's professional life, which is made up of relationships, and what happens when working in a language other than their mother tongue. Indeed, the literature review has also shown that therapists working in their second language may encounter certain difficulties while conducting therapy with their patients. The importance of paying attention to how being an immigrant can have a role in conducting therapy in a different country was noted. It has shown that the therapists' self-awareness of their bilingualism and their personal mourning in relation to their own immigration may determine their capacity to work peacefully with individuals of diverse cultures and languages. The presented literature showed that the therapists' experience of working in a second language with monolingual patients remains under-researched as the focus has mainly been on bilingual patients' experiences and on the dynamics of switching language in the therapy. These were all research studies based on interviews with counsellors and psychotherapists working with adults, and I was unable to find any research on bilingual child psychotherapists.

The above literature, therefore, indicates that further research is needed to address the gap in the literature, investigating psychotherapists' experience in relation to working not only with

adults but with children. A focused study in this area would likely yield valuable insights, particularly regarding the unique challenges and strategies involved in therapy with younger patients. I believe that a study that focuses on psychotherapists working with children and adolescents would reveal that interactions with children might be more focused on play, as this is the way children communicate. A study examining bilingual psychotherapists working with children would likely reveal how language differences impact play-based communication. For instance, it could explore whether language barriers affect the interpretation of play themes and how therapists adapt their approaches to bridge any communication gaps. Additionally, children might be more straightforward about language-related issues, potentially making it easier for therapists to identify and address these barriers in the therapeutic process. Regarding adolescent patients, adolescence is a critical period for identity formation, and having a bilingual psychotherapist could facilitate identity exploration, as certain dynamics might be better navigated within the transference.

The research project that is presented in the next chapter is a first step to cover this gap and to answer the question “What is the experience of bilingual child and adolescent psychotherapists working in their second language?”

CHAPTER 3

Methodology

Introduction

This is a qualitative research project exploring bilingual child and adolescent psychoanalytic psychotherapists' lived experience of providing psychotherapy in their second language. This chapter explains the main aim of the study, ethical considerations, the rationale behind the choice of method, participant recruitment process, data collection, data analysis, and reflexivity.

Aims and objectives

The main aim of this study is to explore the lived experiences of child and adolescent psychotherapists conducting therapy in their second language. In this context, the word "bilingual" refers to a person who has reached a proficient level in a second language in late adolescence or later.

As the use of a second language is also connected with the fact of being an immigrant and thus not belonging to the dominant group, the research aims to explore the emotions and feelings of child and adolescent psychotherapists from minority cultures working in their second language with monolingual patients from the dominant culture, focusing on the transference relationship. Furthermore, this research aims to gain insight into the experiences of using either the second language or the mother-tongue in bilingual therapists' own personal analysis and, in the case of child and adolescent psychotherapists conducting therapy in both their native and second language, the research will also be interested in exploring what emotions and differences arise in working in native and second language. For instance, it will be interesting to know the

experience of a bilingual child and adolescent psychotherapist that works in English but who have also had the experience of working as a therapist in the native language.

Ethics and ethical considerations

Before beginning to contact participants or collect any data from them, I gained ethical approval from the Tavistock and Portman Trust Research Ethics Committee (TREC) (See Appendix 1). The process of data safety undertaken is fully described in the sections below.

The proposed research does not involve any specific or anticipated risks to participants that are greater than those encountered in everyday life. However, I have needed to be aware that the content of the interviews may create emotional upset or discomfort for some participants, as it focused on their lived experiences.

Research design and rationale

Since the purpose of this research question is to elucidate and gain a deeper understanding of the experiences of bilingual child and adolescent psychotherapists working in their second language, a qualitative method was chosen for its capacity to provide a profound insight into individuals' experiences (A. Moser & I. Korstjens, 2017).

I selected the FANI framework (Holloway and Jefferson, 2000) for data collection, judging this the most appropriate qualitative method available, and chose interpretative phenomenological analysis (IPA) for data analysis.

As will be explained in full in the relevant section, I used semi-structured interviews to collect qualitative data. The FANI method for designing the semi-structured interviews helped me to use a very open style of questioning, and to pay attention to the emotions, thoughts, anxieties,

and motivations of each participant, including both the conscious and unconscious dynamics and processes. It also allows interviewers to follow the participants' own narrative and to elicit meaning from it that may be previously unknown or unprocessed.

IPA was selected as the most appropriate qualitative method of data analysis for this research project. Indeed, IPA is used for in-depth examination and exploration of how people make sense of their life experiences (Smith et al., 2009), and assumes that individuals are "self-interpreting being[s]" (Pietkiewicz & Smith, 2014, p.8) who play an active role in the process of making sense of what happens in their lives. IPA is founded on the theoretical perspectives of phenomenology, hermeneutics, and idiography (Pietkiewicz & Smith, 2014). IPA involves a double hermeneutic process, initially focusing on understanding the meaning that participants give to their life experiences (phenomenological approach), and the researcher then makes an in-depth analysis of the meanings that participants give to their experiences (Smith and Osborn, 2008), which is helpful for analysing the data. IPA is idiographic, as it pays attention to the particular and individual case over the general (Smith, Flowers and Larkin, 2009). Furthermore, IPA recognises that researchers have their own natural biases and assumptions, and emphasises the importance of reflecting on how these factors impact the research (Eatough & Smith, 2017). This will be taken into consideration in the paragraph on reflexivity, below.

As IPA takes an intimate focus on one person's experience and explores how people may relate to their significant life experiences (Smith, Flowers & Larkin, 2009), I evaluated that IPA was the most appropriate qualitative research method with which to understand the emotional experiences of bilingual child and adolescent psychotherapists conducting therapy in their second language.

Participants

The sample of this research was composed of six bilingual child and adolescent psychoanalytic psychotherapists—4 females and 2 males—registered with the Association of Child Psychotherapists (ACP). The relatively small sample size followed IPA guidelines, which allow for detailed, in-depth, and at-length analysis of any individual's lived experience of a specific phenomenon (Pietkiewicz and Smith, 2014). The participants had an age range of approximately early 30s to mid-80s. The participants' clinical experience ranged from being in training to being highly experienced, with approximately more than 15 years of qualified work. The rationale behind this was that there may be significant differences between the experiences of bilingual trainees, newly qualified, and more senior child and adolescent psychotherapists. The participants were coming from Germany, Greece, Israel, Italy, Spain and Hungary.

The inclusion criteria for taking part in this research were:

- have reached a proficient level of competency in their second language in late adolescence or later.
- being registered with the Association of Child Psychotherapists (ACP) and having a wide range of length of experience, spanning from trainee to highly experienced (more than 15/20 years of qualified work).

The exclusion criteria were:

- to not have been exposed to the second language since babyhood, for instance by not having a parent who had English as their native language.

The initial aim was, then, to only include child and adolescent psychotherapists who had reached a proficient level in a second language in late adolescence or later. Furthermore, I felt it was important that the participants were not exposed to the second language since babyhood. However, I realised that the exclusion criteria were not made explicit, as I assumed that if a participant reached proficiency in the second language in late adolescence, they would not have been exposed to this second language since babyhood. The first five participants that I interviewed followed the above criteria, however, while interviewing the last participant, it emerged that one of their parents was from the UK. The interview was not interrupted but careful thoughts were given in the evaluation of whether this specific participant could be included in the data analysis. The participant perceived English as their second language, never having spoken much English at home, and had only moved to the UK in their late twenties. After talking this through with my supervisor, I decided that it was important to acknowledge the lived experience of this participant who, while having a native English parent, perceived English to be their second language. On that basis, I decided to include this participant in the sample. The rationale behind this decision will be further explored in the Reflexivity section below.

In the Findings section, the pseudonyms were assigned in a non-gender specific way due to the small number of bilingual child psychotherapists from some specific countries, with the aim to maintain the highest level of anonymity for participants. I thought with my supervisor about adding a table that specifies pseudonym, country of origin, and the years of experience as a child and adolescent psychotherapist for each participant. However, it was thought that the participants may be too recognisable if the nationality and the years of experience were linked together, and the table was omitted for this reason.

Recruitment process

I used a purposive sampling methodology to identify participants. This technique is widely used in qualitative research for the identification and selection of information-rich cases (Patton, 2002). The aim of this method is to obtain knowledge from individuals with particular expertise, which in turn will result in the gathering of qualitative responses that would lead to better insights and an in-depth exploration of each participant's experiences. Indeed—following the idiographic approach of IPA—this would enable me to capture rich and subjective experiences pertaining to these individuals (Smith, Flower & Larkin, 2009).

Participants were recruited by sending the research project "Invitation letter" (see Appendix 2) to bilingual child and adolescent psychotherapists via email, along with a participant information sheet (see Appendix 3). The participant information sheet included a more in-depth explanation of the research, such as the background and rationale of the study, information on interview duration, data protection, and ethical approval. Participants who expressed their interest in taking part were given a further opportunity to ask questions and, if necessary, at least 24 hours to decide whether they wanted to take part in the study. Once they had provided verbal and/or written consent they were given a consent form (see Appendix 4) to be signed and returned to me.

Participation was voluntary and participants were aware that they had the possibility to withdraw their consent without giving a reason up to two weeks after the interview had taken place; all the forms were stored in a protected research file that only I have access to. No participant withdrew their consent. Once consent for an interview had been given and signed, I contacted participants and arranged a time to meet; in the context of COVID-19 pandemic, the participants were provided with the option for the interviews to be conducted in person or

via video-conference using the Zoom platform. Two participants preferred to be interviewed face-to-face and the other four were interviewed via Zoom.

I approached bilingual child and adolescent psychotherapists at staggered time intervals to ensure there was no over recruitment. In total 8 Child and Adolescent Psychotherapists were approached and 6 agreed to participate.

Data collection

Semi-structured interview design

I designed a semi-structured interview (see Appendix 5)—which is the most accepted method for data collection in IPA (Pietkiewicz and Smith, 2014) — to elicit rich and detailed narratives of experiences. As anticipated above, in order to access the deepest layers of unconscious meanings of participants' experiences, I relied on a specific free association interview method (FANI) (Holloway & Jefferson, 2008).

I felt this to be an appropriate interview technique as it helps to minimise unconscious defences, which may be activated in both interviewer and interviewee when dealing with anxiety (Holloway & Jefferson, 2008). The theoretical background underlying FANI postulates that participants are "defended subjects", who will mobilise unconscious defence dynamics to cope with anxiety (Holloway & Jefferson, 2008). These defence mechanisms may have a negative impact on different domains, such as transparency, ability to recall distressing events, and communication. I believe this to be particularly important for this study, as it is likely to stir up complex emotions related to being an immigrant working in a second language within a social context with a different dominant culture. Since this topic may be quite painful, as it is deeply related to identity dynamics, it could give rise to conflicting emotions.

Data collection procedure

I sent each participant the interview questions and possible interview prompts to read beforehand, to encourage focus on particular areas specific to the research aims. Participants were not required to read the questions before the interview, and indeed not all participants did, as they wanted to enable free associations. The interviews took place at a day, time, and place suitable for the interviewees and they lasted between 35 and 70 minutes.

The interviews were audio-recorded using a voice recorder and, as a back-up, the interviews were also recorded on a mobile phone. The audio recordings of the interviews were saved on a password-protected laptop, and then deleted from the voice recorder device and the mobile phone. Using the application Otter, I listened to each recording multiple times and transcribed the interviews. These transcriptions formed the data set.

After the interview, I sent a debrief letter (see Appendix 6) via email, which provided specific post-interview information regarding support with any unforeseen impact of interviewing or concerns that might have arisen during the process. I also made participants aware of the possibility of being contacted via telephone, Zoom video conference, or email in order to respond to any potential post-completion queries or concerns, and of the possibility to accommodate a follow-up conversation after the interview, if requested. This was done so as to minimise potential distress.

Confidentiality and data storage

All participants were informed, verbally and in writing (in the consent and information sheets), of steps that would be taken to protect their confidentiality. They were notified that, due to the small sample, some data used in the study might be identifiable but that I would try to minimise this as much as possible.

Participants were made aware that the data generated over the course of the research would be retained in accordance with the University of Essex data protection policy and the Tavistock and Portman NHS Foundation Trust. Participants were also informed that I would act as the data controller for this study and be responsible for looking after the information shared and using it properly, and that the data would be stored for two years after the study had been concluded.

Data analysis

The transcripts of the interviews were analysed using the new terminology and the IPA steps of analysis described by Smith & Nizza (2022).

Initially, the process consisted of reading and re-reading the interviews on an individual basis. This allowed me to become more familiar with the data and to increase the initial understanding of participants' experiences. Then, for each transcript, I proceeded to write exploratory notes directly on the electronic version of the transcript, in the column to the right of the original text (see Appendix 7). This process provided me with an in-depth analysis of each interview and produced a substantial data set before moving on to develop experiential statements. In formulating the experiential statements, I had to summarise what emerged as important in the notes, finding a balance between being specific, basing them on the data, and conceptual, by capturing the deeper meaning of the data (Smith & Nizza, 2022). The experiential statements were written in the column to the left of the original text (see Appendix 7). After identifying the experiential statements, I created a list containing these, then moved them around to find connections and form clusters. Once the clustering felt satisfactory and meaningful, for each cluster, named "personal experiential theme", I had to find a title that would convey the

meaning of all the experiential statements brought together. I then created a table of personal experiential themes for each interview (see Appendix 8).

After this, I began comparing across cases. I printed out all the tables of the personal themes of each interview, positioning them on a surface where they could be reviewed more easily. This was done in order to find connections, similarities and differences between tables of personal experiential themes. Finally, I created a table of group experiential themes. A detailed account of the outcome of this process can be found in the Findings and Discussion chapters.

Reflexivity

Kathryn Haynes (2012) defines reflexivity as "an awareness of the researcher's role in the practice of research and the way this is influenced by the object of the research, enabling the researcher to acknowledge the way in which he or she affects both the research processes and outcomes" (p. 2).

To gain a deeper understanding of this study, and due to the personal and professional involvement of "me" as a bilingual researcher and child and adolescent psychotherapist, reflections are needed in order to explore what influenced my decision to investigate this topic, and acknowledge how I form part of the research process and outcomes. My motivation for choosing this area of study comes from my own experience of being a bilingual child and adolescent psychotherapist. I studied psychology in my mother tongue, and I learned my second language in my early twenties. I moved to the UK in my late twenties and started my career, my training, and my personal analysis in English, my second language. With time, I started to realise that bilingualism was a vital element of my individual, emotional, and professional identity. One day, I came across the line "This language is beginning to invent

another me" (Hoffmann, 1989, p. 121). This made me reflect on how I was a different person in my second language. I began to think about my work with English-speaking patients and wondered how my bilingualism affected different aspects of the therapeutic relationship. I reflected on the possibility of having two different selves linked to the languages that I speak.

In my second year of training, at my work placement in a generic CAMHS, I got the opportunity to work with a patient in my mother-tongue and I thought it would be easier to establish a therapeutic relationship as we shared the same language. However, I noticed that making interpretations and thinking psychoanalytically in my first language was much more difficult than I had thought, probably because my psychoanalytic language was integrated with my second language. I also felt it was more difficult to set boundaries with the patient, as their painful experience of being a foreigner resonated with me more intensely, and I felt I needed to defend myself from these feelings. This clinical case triggered my curiosity on bilingualism in a therapeutic setting. I then developed a desire to explore the feelings of other bilingual child and adolescent psychotherapists, in the hope of gaining a better understanding of the emotional impact of working in a second language.

As a researcher, I was aware that these experiences could not be put aside, and I could never be objective in my encounters with the participants. Both the method I chose to interview them, FANI, and the method I chose to analyse the data, IPA, allow space for these to be acknowledged and form part of the research process. Indeed, Holloway and Jefferson (2000) reflect on the impact that researchers can have on the representation of the voices of those that are studied. They stress that it must be acknowledged that what researchers understand from the data is an interpretation affected at least by their own experience, knowledge, understanding, and motivations. On the other hand, Smith and Osborn (2003) speak about the

double hermeneutic cycle as an important part of IPA. “Double hermeneutic” is a concept that describes me making sense of what the participant says, which is the participant’s own way of making sense of their experience. I experienced this double hermeneutic even during the data collection procedure: how both my knowledge and understanding were challenged by the participants and conversely, how the participant’s knowledge and understanding were influenced by me being, like them, a bilingual self.

Indeed, when developing my research project, I felt strongly that child and adolescent psychotherapists who have an English parent would have to be excluded from the study, as I assumed that, for them, it would not be so complex to work in English as they were exposed to the language since babyhood. I wrongly assumed that they would not have the same feelings as child and adolescent psychotherapists who had not had these early experiences of the language. At the beginning of one interview, a participant told me that their parents were English. Although the participant told me that he/she did not feel that English was their mother tongue, I explained that we could not continue the interview as it was important for this study that parents were not from the UK. After this episode, I started to question if it was my own assumption that child and adolescent psychotherapists who had been exposed to English since babyhood could not consider English as second language. While I was interviewing another participant, it emerged that one of their parents was from the UK. As we were almost midway through the interview, we continued anyway. I was surprised to realise that the participant had similar experiences to the other participants (who did not have any parents from the UK) and myself. After the interview, I reflected with my supervisor, my analyst, and my research supervision group about the reasons why I did not want to include this particular participant in the interview. I realised that according to my own assumption, the mother tongue is the language of the parents, even if the child was born in a different country and exposed to another

language since birth. Having realised this about myself, I felt it was important to nevertheless include this participant in the research, as their perception is that English is their second language.

Some of the participants were my fellow trainees and senior colleagues, so I was familiar to them, and I am also a bilingual child and adolescent psychotherapist, so it is possible that the questions I asked participants, how they answered, and how I analysed the data was influenced by our familiarity with one another and with the experiences that they reported. During the interviews, the majority of the participants asked me personal questions about my own experience of being a bilingual child and adolescent psychotherapist, perhaps trying to understand if we shared the same experiences, and I must admit I felt some sense of obligation to respond. I noticed that through the whole process, it was difficult to totally separate my bilingual child and adolescent psychotherapist role from my researcher role, and I had to try to remain as objective as I possibly could. I also believe that as a child and adolescent psychotherapist in training, my research has been strongly influenced by my psychoanalytic background, which was also the lens I used to analyse my data.

In approaching the data analysis—especially when I had to write up the experiential statements and find connections between them—I remember that I felt overwhelmed by the amount of data that I had, and I found it difficult to discard some experiential statements as I felt everything was essential. I felt stressed as I wanted to make sure I captured the experiences of bilingual child and adolescent psychotherapists to the best of my abilities.

As time passed, the data started to rearrange itself in a different form through various connections and opposing links. The process involved trial and error as I engaged in activities

such as reading, writing, highlighting, colour coding, typing, and printing, before finally arranging all the tables of personal themes of each interview on the floor, eventually creating the final table of group experiential themes.

I found the process of using IPA unique and surprising; it felt like navigating through darkness. I believe that each participant provided a distinct set of knowledge and experiences and I reflected on them during the data analysis. It became clear that this process highlighted and shed light on the individuality of relational experiences.

CHAPTER 4

Findings

Introduction

This chapter will report on the analysis of the data, which has been completed with the use of IPA, following the stages described in Chapter 3. From the data analysis, four recurring group experiential themes emerged: navigating cultural and linguistic challenges in therapy, the impact of therapist's foreignness into the transference, coming from another country: the painful journey of immigrant child and adolescent psychotherapists and therapist sense of self: where do I belong? Table 1 shows each group experiential theme and subthemes. Appendix 7 contains an extract from an interview that shows how the experiential statements were extracted, while Appendix 8 shows how the experiential statements were grouped and collapsed into personal experiential themes.

Table 1. Structure of IPA themes: Group experiential themes and subthemes

Group Experiential Themes	**Subthemes**
Theme 1 **Navigating cultural and linguistic challenges in therapy**	Struggle to understand cultural references, idioms, slang, concepts and to express yourself
	Managing difficulties and the perception of difficulties over time
Theme 2 **The impact of therapist's foreignness into the transference**	Patients' projections into the accent and culture of the therapist
	Foreignness as a bridge for the therapeutic journey
	The therapist as a patient
Theme 3 **Coming from another country: the painful journey of immigrant child and adolescent psychotherapists**	Painful experiences
	Longing for integration and acceptance
Theme 4 **Therapist sense of self: where do I belong?**	Identity across two different languages and cultures
	The importance of the mother tongue

The themes provide an interpretative account of the participants' experiences of working and having their own analysis in their second language, as well as their experiences of their own identity across two different languages and cultures. In the following sections, the results are reported by addressing each group experiential theme with the relevant subthemes. The quotes from the interviews are highlighted in italics, and used to illustrate the journey of each participant. These quotes are narrated with comments on their subjective interpretation to support the group experiential themes that came to light through the analysis. Indeed, interpretative analytic comments on the material transpire in the process of capturing the lived experiences of the participants.

To protect participants' anonymity, pseudonyms are used throughout the dissertation. They will be referred to as Jack, Sarah, George, Lily, Thea, and Odette. The pseudonyms do not necessarily indicate the gender of the participant.

Group Experiential Theme 1: Navigating cultural and linguistic challenges in therapy

This theme captures the efforts and struggles of all participants to understand the patient while conducting therapy in their second language. This is demonstrated through descriptions of some challenges the participants encountered, and how they managed them. Participants also describe how the perception of difficulties changes over time, and how this is linked to their clinical experience and acclimatisation in the new country. These are illustrated in the subthemes below: "Struggle to understand cultural references, slang, idioms, concepts and to express yourself" and "Managing difficulties and perception of difficulties over time".

The first subtheme explores the challenges faced by participants as they navigate a new linguistic and cultural landscape. These challenges often lead to feelings of inadequacy and concerns about their ability and confidence to fully understand and effectively communicate

with their patients. The quotes from the interviews illustrate the complexities of deciphering cultural nuances and the anxiety associated with potential misunderstandings. For instance, participants recount experiences where unfamiliar terms or idiomatic expressions led to confusion and a sense of alienation, highlighting the complex link between language and cultural understanding. These struggles are not merely about translating words but involve grasping the deeper cultural contexts and societal norms embedded in the language.

The second subtheme focuses on how participants manage difficulties that are associated with not understanding certain words, or concepts, or being understood and how their perception of these challenges changes as they gain more clinical experience and become more acclimatised to the new culture. Participants describe various strategies they have developed to cope with language-related issues, and how their increasing confidence allows them to turn initial vulnerabilities into therapeutic advantages. Over time, bilingual child and adolescent psychotherapists learn to use their bilingualism as a bridge rather than a barrier, leveraging their unique position to foster deeper connections with patients.

Together, these subthemes shed light on the intricate relationship between language, culture, and clinical practice, emphasizing the struggles and resilience of bilingual child and adolescent psychotherapists as they strive to provide effective therapy in a second language.

Struggle to understand cultural references, idioms, slang, concepts and to express yourself

In this subtheme, all participants described the challenges of understanding patients or colleagues when working in their second language. These struggles frequently result in feelings of inadequacy and worries about their ability to fully comprehend and communicate with patients, highlighting how gaps in cultural knowledge impacted their confidence.

The majority of participants talked about the difficulties that they faced—especially at the beginning of their career, when they first moved to the UK—in relation to understanding cultural references:

> *When I started the M7, I just moved from my birth country, and I didn't have any period to adjust. And I remember I had no idea what CAMHS was. I remember in the presentations, they were talking about CAMHS, and I was asking what CAMHS is because I had absolutely no idea, I didn't even know the basics.* Lily

Lily talked about her experience of attending seminars and finding that she did not understand some cultural references, like CAMHS, that she referred to as "basics". This word seems to capture her feeling of inadequacy for not knowing something that she imagined every person that works with children in the UK should know. Sarah reported a similar experience when she described how she felt when she did not know something that in her opinion, everybody knows, and she needed to ask her colleagues for an explanation:

> *I remember in the training in one of the seminars, I think it was young child observation, and they spoke about "flapjack", and I didn't know what it was. And it's such a stupid thing. But you feel so stupid. Everybody eats it all the time. But I remember that I had to ask them, and they had to explain. So, this is just a small example that you think "Oh, my God, you're really stupid".* (Sarah)

Sarah highlighted the complexities of not understanding cultural references and the effects this might have on her confidence. In the above extracts, it becomes clear how Lily and Sarah both convey the fear of being judged for not knowing something important. George describes a

misunderstanding relating to an idiomatic expression he thought carried a completely different meaning:

> *I mean, for instance, you know, I didn't know what it meant to go to somebody for tea, and I thought it would mean to have a cup of tea. And so there were some misunderstandings with English children going for tea to a friend. And, you know, I didn't quite understand it.* (George)

What seems to emerge from the data is that there is a strong link between language and culture, which shows that learning a new language is not just learning the meaning of the words and grammar rules, but it also implies learning societal norms and cultural traditions. Indeed, the participants felt concerned about failing to understand their patients, and an important question arose: is it really possible to understand the patient if not every single word or meaning is understood?

In the extract below, Sarah describes how she worried, especially at the beginning, that patients could not understand her, or that she might not understand them.

> *But I think it is about the way you speak to people, and what I found it very difficult at the beginning, I was worried they might not understand me. The accent, which I still have, not so much, but I still have it. But I was worried that when you start working with young people they might not understand. Or I might not understand them, which was at the same time, I think, parallel to the culture, that I didn't know about television programmes. I didn't know what children are watching. What are*

> *adolescents watching? Maybe a few things I knew, but some of the things I didn't and I still don't know.* (Sarah)

The worries described above stir up, in the therapist, feelings of inadequacy and not being good enough, and the fear that there will be a barrier to communicate with patients. Sarah talked about the fact that in therapy the aim of the work is to understand the patients in any way possible, but if the therapist comes to a different country and speaks a different language, they may have a '*double worry'*, first in relation to being a good therapist and understanding the patient, but also regarding language skills. This was also illustrated by Lily when she gave an example of working with an adolescent who she felt did not speak clearly. He tried to use the Queen's English and she struggled to understand him.

> *And then I can come across with my own incapacity to understand them or use English. Or to just being in this foreign country providing therapy to those little ones. I try to get exactly what they're trying to communicate to me, but then I ask myself if I can pick up the unconscious if I don't understand a word? So, it provokes a kind of not a huge amount of anxiety, but it provokes anxiety.* (Lily)

In Lily, it seems that this gave rise to feelings of inferiority and an awareness that she comes from another country and that not everything will be understood, up to the point at which she doubted her capacity to provide therapy to children. Thea and Odette experienced not understanding their patients when they were using slang or difficult words. Thea talked about how, when something is not understood in therapy, something important can be lost, and reflected on how this could be used in the therapy:

> *For instance, I work with a young boy who uses slang all the time. This is also my intensive patient. So, he's very much into sort of street culture. And some of the words he uses, I don't really understand any of it. I don't think an English person would either. It is slangy. But then it becomes something about where he knows, and I don't know. It becomes much about differences. Then I have to come to him to understand what that means. And then it's up to him really, whether he lets me in or not, and a lot of the time, it's about keeping me out, really. So, I think it's very interesting how maybe language can be sometimes useful, really. And also, I think it maybe contains something that he doesn't want me to understand and he's protecting himself from it.* (Thea)

Thus, Thea reflected on how not understanding the slang of the patient helped her to make sense of the difficulties that the patient was experiencing. Similarly, Odette made use of her countertransference of feeling inadequate, stupid, and ignorant in relation to not understanding her patient to be in touch with her patient's anxiety.

> *I remember one little boy and he was reading George Orwell in the waiting room. And that's how he was talking in the sessions, very, very big words. I really didn't understand some of his words, I think in every second sentence, there was something I wouldn't understand. It wasn't necessarily coming from me, even though it felt like it at times, it was just because he used these words completely out of context. And it felt that he had to come to the sessions and perhaps control me, outsmart me, you know, be the one in control and that was one of his tools. And at times, I felt, "oh my god", you know? I haven't read George Orwell, not yet, what does it mean? I started to notice that he was trying to make me feel not*

> *very smart, stupid, really, and as somebody who doesn't understand anything, and who was not as intelligent as him. Which was very much linked to his anxiety of coming to see me.* (Odette)

These accounts show how the therapist's experience of not understanding something may make them feel inadequate or not good enough, and might impact on their confidence. On the other hand, these experiences can also be used as tools for understanding, not the exact words that the patients are saying, but the experience behind the words and the relational dynamics that are played out between the patient and the therapist.

Another difficulty reported by the participants was the challenge of expressing some concepts in their second language. Jack highlighted this when explaining that his language proficiency can fluctuate, and that this is linked with the confidence felt in any given situation.

> *I think for me it happens when I really need to express something and I am with someone who I perceive as not listening, in the way I need them to listen to me. So, I think it is more relational other than the language. It is more related to the questioning, you are thinking more about what you want to express. So, there is an empowering feeling, perhaps. So, I think, it is not connected with the language but more about relationships.* (Jack)

In all the above quotes, participants express certain struggles they have faced while conducting therapy in their second language, and how these would at times impact their confidence.

Managing difficulties and the perception of difficulties over time

In this subtheme, all participants describe how they manage difficulties that are related to not understanding certain words, or concepts, or to being understood. It transpires that participants use the transference and therapeutic techniques to resolve these issues. This subtheme also shows that the perception of challenges changes over time, or, as George put it, '*diminishes as you become more acclimatised, more familiar with the culture*'. It is also reported to diminish when the therapist feels more confident in their clinical experience. Indeed, George explained that, at the beginning of his career, he felt insecure about his language skills and if there was something he didn't understand, he found it difficult to ask for clarification, perhaps out of fear that his language skills might be criticised: '*I tried to make out what was being said from the rest of the sentence'*. However, he then reported that now, after years of experience, he has no difficulty asking for an explanation. Sarah reports a similar experience in the following quote:

> *And this is the problem that I think when you are at the beginning you don't know what to ask and what not? Is it okay to ask? I definitely know now. There might be words that I don't know. It doesn't happen a lot. But let's say that in supervision, someone says something, and I forgot the meaning of the word. And it's quite important. So, I'll have to check quickly the meaning of it. But if I work with patients, I think I feel more comfortable to say, "Well, I didn't understand this" and to ask them, but at the beginning you don't.* (Sarah)

Sarah here conveys a sense of feeling inadequate when she does not know the meaning of a word while with colleagues, and will look up the meaning of the word without asking, but if something is not understood with patients she would feel confident enough to ask. This seems to indicate how her feelings are linked to the relational experience within which language takes

place, and how her increasing clinical competence gives her the confidence to manage her language difficulties with patients.

Lily and Odette also talked about how they have managed the difficulty of not understanding something in a session.

> *I think that perhaps more at the beginning you can get hung up on certain words, especially if you are aware of your accent, "oh, gosh, I don't understand something", "I didn't understand that one". And perhaps, this means that one can be a bit less flexible and less playful with language. But it's not really about understanding every single word, because it might have a different meaning anyway, I think it's about finding out what they are actually telling you, in the context of that session, that matters.* (Odette)

Odette describes that, especially at the beginning, she was worried about not understanding specific words, but with time she got less preoccupied about this, perhaps as she grew more confident in her abilities as a therapist.

Thea reported that at the beginning, when she was worried about her language skills, she would try to not always use the same vocabulary and expand her ways of expressing herself, "*to try to make up for a deficiency in some way",* and probably mend her sense of inadequacy. With time, she realised that it might be important to use simple language with patients:

> *But I think now I've changed my point of view, and I tend to use really simple language. Because I suppose that working with children and young people, maybe*

> *complicated language is something that doesn't go very well with that. So, I don't know, maybe now that I got more experience, I realised that, actually, it can be helpful to put things in a way that is simple.* (Thea)

She described that at times she found it helpful to say to patients, *"you know, I'm not from here",* and if she did not understand something, she found it helpful to give patients *"some sense of agency".*

As all the other participants, George also explained that at the beginning of his career, he felt insecure about his language skills and about his clinical capacities:

> *Well, that has changed over the years so far. At the beginning, I felt very insecure. As it was also the beginning of my work as a clinician. So, you know, I felt maybe I was putting my foot in it not only by saying the wrong word, but I wasn't so confident about my clinical capacities, which hopefully, you know, over so many years of work, have improved. So now, if I feel that somebody might be teasing me or that if I see that there is something in the dream that seems to, you know, be made making fun of my birth country characteristics, very kitsch one, I interpret it, now I feel the capacity of interpreting.* (George)

The above illustrates how George found it difficult to use the bilingual therapist self in sessions; this capacity seems to grow parallel to feeling more confident clinically, enabling the use of the language within the transferential relationship.

It emerged from the data that, especially at the beginning, bilingual child and adolescent psychotherapists are aware of the fact that they are working in a second language and can at times feel quite vulnerable, criticising themselves about their language skills. These therapists seem to show how their own critics, at times and mainly during the beginning of their clinical experiences, might function as a barrier to a different layer of meaning within the therapy.

In the quote below, Jack gives an example of a situation where, instead of criticising his language skills, he was able to use his bilingual therapist self and reflect on the dynamics that had taken place between him and his patient in parent work.

> *I remembered someone who, I was looking for the right word, and they slowed their speech down extremely, sometimes that happens as well. I'm remembering a stepmother who was feeling attacked, not attacked, she felt very inadequate. Kind of projective identification, and I started to struggle with my words. Looking for the right words. You know sometimes you look for the right words. And then she started to slow her speech down, I could see her mouth. That was tricky. I mean, she was feeling so, so vulnerable, and, and told off and inadequate, even though we were exploring what's going on for her family. I think we took it on the chin.* (Jack)

He was able to notice the parent's sense of inadequacy, which was projected into Jack, who then identified with these feelings and in some ways started to struggle with his words, perhaps feeling inadequate as well.

Group experiential theme 2: The impact of therapist's foreignness into the transference

This group experiential theme focuses on how having a child and adolescent psychotherapist that comes from a different country with a different language and culture, and works in a second language can impact the transference. It captures how these patients can develop a negative transference but also, at the same time, how having a foreign child and adolescent psychotherapist can open new ways to allow patients to access the more painful aspects of themselves. The participants also reflected on their personal analysis and how having a psychoanalyst from a different culture, and speaking their second language in analysis, affected the transference.

The above will be further discussed in the following subthemes: "Patients' projections into the accent and culture of the therapist", in which is revealed how patients' reactions to the therapist's foreignness can manifest as negative transference, as the therapist can be seen as an unreliable object and it can be attacked, impacting the therapeutic relationship; "Foreignness as a bridge for the therapeutic journey", which reveals how having a child and adolescent psychotherapist with cultural and linguistic differences, despite the challenges, can serve as a bridge, enabling patients to engage more deeply with their emotions and personal history. Additionally, child and adolescent psychotherapists' lack of cultural assumptions and simplified language use can empower patients and foster a sense of agency in the therapeutic process. This dynamic can shift the power balance, especially for young patients who find the therapy setting intimidating. And "The therapist as a patient", which explores participants' experiences of undergoing their own analysis in a second language.

Overall, this group experiential theme captures the complex interplay between cultural identity, language, and the therapeutic process, illustrating how the foreignness of the therapist can both challenge and enrich the therapeutic journey.

Patients' projections into the accent and culture of the therapist

This subtheme shows how all participants shared the experience of patients' projections into their accents or culture. It captures how the foreignness of the therapist can stir up some feelings in the transference. It also highlights how misunderstandings and cultural dissonance can reinforce a patient's perception of the therapist as unreliable or incapable of fully understanding them. Additionally, participants discussed how difficulties in communication could be weaponised by patients to undermine therapy.

Odette gave the example of a girl that made a comment on her accent and compared her to someone really strong from her birth country, and Odette was able to reflect on the meaning of this in the transference and how perhaps this patient was letting her know how worried she felt about the therapeutic relationship. Odette reflected that '*Perhaps, some of that stuff would have come out anyway, but the accent and my difference perhaps makes that more concrete*'. Thea emphasised how patients are interested in where the therapist comes from and reflected on how patients can perhaps be scared of something different and foreign. Similarly, in the quote below, Odette conveys a sense of feeling attacked and undermined for being a foreigner:

> *I was doing some parent work. And we were talking about some very risky behaviour. So, her daughter was really engaged in some very risky behaviour. But the mother was kind of playing it down and she was saying, "you know this is what teenagers do." But it wasn't really just the normal stuff, what teenagers do, and something serious could have happened. And I was just curious about what happened to any kind of anxiety or concerns about this, you know, because it didn't seem to be there. And I voiced something about this, and she looked at me and she got furious and said, "I don't know what anxiety means in your country. You know,*

but that that's not what it means here." She got really angry and attacked me. And then we continued to talk about this, and she wanted to explain why I got it wrong, and she explained what anxiety means in English, so I could understand. I think I did say something maybe about it being an attack. I think it was quite remarkable that she needed to explain the word anxiety to a child psychotherapist. It's quite interesting. (Odette)

This illustrates how Odette was then able to reflect on how this woman had a husband with a very strong accent, and wondered if some dynamics were played out. This helped her to better understand what was happening and she was able to take it less personally and to reflect on what the parent was actually trying to communicate through these attacks, which she believed were "*in relation to my accent and me coming from a different country*". Jack described a similar experience in the following vignette:

I had a first online consultation with a mum and dad, and they were in separate places. And the dad was walking the dogs. So, he had awful reception. I was also quite nervous. And I went in, quite without defences, I think. And at the end of this consultation, he said, I'm not impressed with your English. He consulted me for his daughter coming to therapy. I mean, after this, I didn't think we could work together. So that was really, really, really tricky. It was a huge attack. And it's really interesting, because I've been thinking about it, you know, that this it is really helpful also to think about what the young person is experiencing, you know, even though this was directed at the language, but also maybe he couldn't find anything else. But I mean, my English isn't bad. It is just he sounded really angry as well (Jack)

Jack felt really attacked by the comments on his English proficiency, but was at the same time able to reflect on his countertransference and also on how the father's anger was perhaps projected onto him. These quotes elucidate how differences in language and/or different culture may strengthen patients' or parents' perception of the therapist being an unsafe, untrusting, and unreliable object and possibly a therapist that cannot really understand patients' or parents' experiences. George explained that, in his opinion, if some misunderstandings happen in the sessions they can be used as evidence that the therapist is not really capable of understanding the patient as a person. Indeed, in the quote below, he talks about the impact that not understanding cultural references might have on the transference.

> *I also didn't know much about the school system. I didn't know much about half-term, what did he say? Half-term? It doesn't exist in the country I come from. So yes, I think the patients feel not understood if something as important as Term holidays are not familiar to you. So, I think it's very important, in my opinion, in the transference to establish a link with the patient, in terms oh well, I don't want to start putting…but I think, you know, the link of being understood that Bion talks about is a very fundamental one. So, I think, not understanding about some aspects of the culture is at times strengthening the patient's feelings that you are not really understanding them as a person.* (George)

George voiced his worries about showing patients that he does not know or understand something, and reflected on how this can make them feel not understood, but at the same time, this can enable exploration of feelings of not being understood that the patient might experience also in other situations.

Another difficulty, described by participants, had to do with patients struggling to understand the therapist. Thea gave an example of this difficulty with one of her patients.

> *I remember a case with a girl, and we had the review and she said to the mother that at times she found it difficult to understand what I was saying. During the review meeting, the mum felt that I spoke in a way that it was clear enough and so, again, you know, it's a sort of an overlap between what they say about the language or maybe about some kind of misunderstanding that is happening in the therapy with a patient. I think maybe in this case, it has been used as a weapon really to maybe undermine the work. It did come across like that.* (Thea)

Even if it was painful for Thea to hear the above comment, she reflected on this experience. Thea thought that the girl's comment about not understanding her therapist was made to sabotage the therapy and perhaps as a way to protect herself from difficult feelings that were emerging from the therapy. She used this difficult experience to understand something about the patient's experience. Similarly, Sarah reported an example of being and feeling attacked.

> *I have an example of one of my patients, he was my intensive adolescent. He made some comments about Hitler. Then, I took it to supervision. And I think we understood that this was his way of attacking me. So probably he understood I am Jewish, this was his way to attack me. Adolescents try to attack adults and you choose something to attack with. And this was something that he used definitely to dismiss, actually it was more than dismiss, it was to humiliate.* (Sarah)

Here, Sarah describes this difficult experience with a patient who attacked and humiliated her for her culture and on something that could make her feel vulnerable. This stirred up difficult feelings in her and she used supervision to reflect on her countertransference and transference dynamics. Some participants voiced difficult and painful experiences in the therapy with patients, however, Lily and Jack spoke about patients who had tried to comment about their birth countries, showing that they had some knowledge about these places. This elucidates how the patients had probably wanted to find a way to connect with them.

Foreignness as a bridge for the therapeutic journey

In this subtheme, the benefits of having a bilingual child and adolescent psychotherapist on the therapeutic journey are described; it highlights how the therapist's foreignness can become a therapeutic opportunity, facilitating a deeper engagement and understanding in the transference and in the therapeutic relationship.

Odette thought about an example of a patient who did not feel understood, and she was able to say to him, "*that he was sitting in a room with a therapist who has an accent, maybe he doesn't always understand me, maybe I don't always understand him. I think he was denying it. But it is something that might come up."* Odette voiced that being from another country gave an opportunity for the issue to be named and for doing some work on what it meant for the patient to not be understood.

Sarah reflected on how her experience of moving country helped her to better understand the experience of feeling, or being, an outsider and how it feels to not belong, and how she can therefore provide a level of comfort or understanding. In her opinion, this can help patients to

feel more understood, especially ones that feel different. Thea talked about another benefit, which is the feeling that not knowing or understanding something in the sessions can switch the power dynamics and help the young person to have a sense of agency in the therapy that can at times be quite scary.

> *So, benefits, as I said, it can give some agency to the child, when perhaps you can say, "I am not from here, and I don't understand how things work". So, you can use your foreignness in order to give some control to the child, especially when there are children who find therapy, or the therapeutic setting, very intimidating. I think that can be quite beneficial. And I think this might work quite well with some teenagers, for instance they can feel they need to help you to understand something. And being a foreigner and not understanding something maybe allow that to happen.* (Thea)

Furthermore, Thea voiced how not having a very broad vocabulary can be used to the therapy's advantage, because children and young people can better understand a simple and clear language. Lily highlighted another important benefit in relation to not being able to make assumptions, as explained in the following vignette:

> *If I know you are from my birth country, I can make assumptions, for instance I can assume from which kind of family you come, or from which part of the country you are. Which is bad as I don't wait for you to tell me, I make my own idea. So, in English, I don't do that. It is what I receive in the room… in English it is like tabula rasa, you come, I meet you, as English is not my language, I cannot make assumptions about class or whatever.* (Lily)

Lily thought that her not belonging to the English culture had made it easier to enter sessions without assumptions, helping her to stay just with what the patient brings to her in the room.

The therapist as a patient

This subtheme captures the participants' experiences of having analysis in English and how they felt when something was not understood in the session because of the language and cultural barrier. None of the participants had analysis in their native language, but had it in English, some with native English-speaker analysts, and some with bilingual analysts from a different country. The majority of participants decided to have analysis in English as it would help them to speak psychoanalytical language in English and to feel more comfortable about working in English. However, Jack and Odette never thought about the possibility of having an analyst that spoke their mother tongue. They both said that they had "*never thought about it".* This may indicate some difficulties with their own country and mother tongue.

Sarah, when thinking about her own analysis experience, felt that she found it difficult, at times, to find the right word with which to describe her experience, and she sometimes felt that the exact translation of some words might just not exist. This made her feel frustrated, as she could not really express what she wanted, but what is important is that she felt supported by her analyst.

> It is always difficult to know if she doesn't get my culture or she doesn't get me. Because I think this is the most scary for everyone. Do they really understand? Or do they get me? She was a good analyst. Sometimes she did ask me, "how do you

> say this specific word in your native language?" Just as she could hear how I express it, and then she used it. And there are some words that it's so frustrating that you can't say them. They are not the most important, but there's something that you just can't find a word to describe something exactly. So, there is a bit of sense, do they get my experience? Because the word is not exactly what is in your mind, as the definition is near but not exactly. (Sarah)

Sarah explained that she used some words in her mother tongue in the session, so her analyst could get a sense of how it sounded, probably helping to make them both feel closer. Like Sarah, Thea described the challenge of translating some concepts, idioms, or expressions from her mother tongue into her second language. She felt it was not always easy and she was not sure her analyst could understand, in deep, certain concepts of her mother tongue.

> *I think there have been times where I wanted to say something that, in English, I couldn't express it in a similar way. But I don't know whether that has got to do with the way one feels about one's own language. Maybe or, you know, I don't know. I mean, for instance, today, we were talking about dreams and there was a reference to a bull in one of the dreams and there is an expression in my native language that it's got to do with a bull and is linked with bullfighting. I don't think she would have been able to understand it unless I explained it, and I still think she seemed a bit puzzled by it. But I think, probably an analyst from my birth country would have got it straight away that it wasn't so much maybe about the bull, but it was more to do with the expression itself that has something to do with procrastination, for instance.* (Thea)

When Thea's analyst "*did not get* [the reference of her dream] *straight away"*, she felt frustrated and reflected that "*something is lost",* adding that she felt it could never be like communicating with someone that speaks and understands her mother tongue, conveying a sense of loss. In the same way, Lily realised that having her analytical sessions in her second language can be quite frustrating, especially when something is not immediately understood due to cultural difference, or when she needed to translate idioms from her mother tongue to English.

> *So, I think, you know, sometimes I can get a bit upset or frustrated, like, "if you were from my birth country now, you would know what I mean". Or, you know if I gave you this explanation, you would understand perfectly fine what it means for our culture, or what happens in my birth country. And so, I have to explain to my analyst phrases that either I don't know in English or don't exist in English, and I need to translate them concretely and directly. They don't make sense and then I have to explain them, which makes the work a bit funny and fun, actually. But yeah, I don't know, if your analyst is from a different culture, how much can they pick up on the culture*. (Lily)

She also talked about the fact that if there are some misunderstandings relating to the language, she can get angry at her analyst, but she can talk about it and it can become material for the therapy. Most of the participants reported feeling frustrated in analysis. Odette felt frustrated when her analyst failed to understand something, but she was simultaneously doubting herself, her accent, and perhaps her language skills.

> *I remember, when my analyst didn't understand what I was saying, how frustrated I felt, and I often thought it is obviously because of my accent, because of me. And I remember my analyst saying something about this. And it might not always be about me, maybe it's a two-way process, isn't it? Also looking at somebody makes a difference, doesn't it? Because if you, if you see them, especially if you maybe don't know every word, maybe it makes it a bit easier to understand each other sometimes. If you're a foreigner perhaps you rely more on body language.* (Odette)

Odette voiced something important, explaining how, as a foreigner, it can be difficult to rely on just your language skills, and so body states and non-verbal sensory awareness become crucial.

When thinking about misunderstandings in own analysis, George gave an example of him having felt misunderstood by his analyst when he had found it difficult to accept an association that his analyst made.

> *I think with times, I only found that I have very much resented misunderstandings in my associations, because there might be a word that sounds like you know, something sexual in English. Like the word for pine trees in my mother tongue. Which in English sounds something like penis or genitals, but I think in my mind, you know, I spent my childhood playing in a pine forest, and I don't relate that sound to that. I had a real misunderstanding with my analyst over that, that I was not accepting that the word was not related to something sexual because of resistance.* (George)

George voiced his resentment towards his analyst, and he then reflected on how those misunderstandings could bring distrust in the therapy. On a different note, Lily, Thea, and Jack explained that in their analytical sessions, without even realising, they said some words in their mother tongue. Thea thought they "*were coming from the unconscious",* Lily used them as a "*reflex",* and Jack when he was "*free associating".* This reveals a need for using the mother tongue in one's own analysis. Jack, differently from other participants, found it quite difficult to think about this question, and he did not describe feelings of frustration towards his analyst because of the difference language or culture, but actually felt that his analyst helped him to accept his birth identity.

> *My mother tongue is a completely different language. I mean, it is not related to any other language. Because of my own background, I think it was also really important that I could, I don't know my identity was a different world. Oh, gosh, it's so difficult to conceptualise this or to put it in words or sentences. Sometimes I spoke in my mother tongue. You know, when I free associated, I mean, it's hardly ever happened. I can't remember the context, my analyst was very open to it and then I could translate and then we could think about what you know, where it came from. So it was a space to discuss, also for me. My analyst really helped me to embrace my birth country identity.* (Jack)

Group experiential theme 3: Coming from another country: the painful journey of immigrant child and adolescent psychotherapists

This group experiential theme illustrates painful experiences of the participants relating to being an immigrant therapist that works in a second language. It reveals the painful experiences of participants as they navigate professional environments where their

language skills and foreign origins often lead to feelings of rejection and attack. These experiences are deeply connected with their desire for acceptance and integration into their new cultural context. They will be described in greater detail in the subthemes 'Painful experiences' and 'Longing for integration and acceptance'. Overall, this group experiential theme captures the complex relationship between language, identity, belonging and the ongoing quest for acceptance.

Painful experiences

In this subtheme, 4 participants gave examples of feeling attacked and stigmatised in situations with colleagues, supervisors, or parents, because of their language skills or coming from another country. They all mentioned feelings of pain. Participants shared experiences of being criticised, ridiculed, and undermined, which profoundly affected their confidence and sense of belonging. The following quotes highlight the profound impact of language and cultural prejudices on the participants' sense of self and professional confidence.

Jack described a situation with some parents in a case in which he was the care coordinator.

> *My language skills have been questioned, or my accent has been picked up. I am the case holder, care coordinator clinician. And I was trying to get in touch with his parents and didn't have any success. I left several voicemail messages which it was so uncomfortable anyway. And then I heard back from a colleague who is English that they don't want to work with me because they don't understand my accent. Interestingly enough. (…) That was really painful and horrible. I felt deeply wounded in a narcissistic way. I don't like to think about this, I guess it's my*

> *assimilated part of me that I don't like to think about that this is my second language.* (Jack)

These words seem to capture Jack's feelings of being stigmatised and discriminated against. He explained that, at first, he found it difficult to work with them but he then thought about the young person who needed a lot of support, and he was able to feel less hurt. It was difficult for Jack to hear these comments as he feels that English is more than a second language to him. Moreover, Odette reported that in her first in the UK, working in therapeutic communities, encountered children telling her "*why don't you go back to your country*" or "*you can't even talk properly*". She explained that it was quite hard for her to hear these comments as they mirrored her doubts about her professional and language skills. She also had an experience of a mother and a patient saying that did not want her as a therapist because she was a trainee and a foreigner.

> *And I had this meeting with my service supervisor, and I remember the mother saying to my service supervisor that actually, they didn't want me as a therapist because I was a trainee and a foreigner. And she just had a trainee psychologist, a man who was a foreigner and it ended in a really complicated way. So, it was kind of around straightaway from the beginning of the training. And, obviously, my service supervisor at the time had to explain that I was a different trainee, and I was not leaving after six weeks, and this would be a different experience, and we worked something out. But I was always made aware of that straightaway. I guess, me being a foreigner was one aspect of all of that.* (Odette)

The above quote elucidates how Odette felt attacked, hurt, and also stigmatised for being a foreigner. She voiced feelings of rejection, and reflected on how feeling rejected can affect one's confidence in one's language and professional skills. Similarly, Thea felt that her confidence was affected by the comments of her supervisor.

> *I remember being with my supervisor and she was really worried about my level of English. It's something that she kept raising as an issue, whereas nobody else had, up to that point. So, it felt very weird. I think it felt quite personal actually, and I started to think whether I was going to be able to process things quick enough and respond to things quick enough, in a second language. I think there was a lot of worry about that. And I think it's something that it never came up in the interview, and it never came up in other contexts, it would come up just in supervision. And it made me feel very worried about it, and quite persecuted really. There was something about my language and my identity that was getting in the way. But I don't know whether there was any truth in that really.* (Thea)

Thea described feeling attacked and criticised. Consequently, she started to feel insecure, and she doubted her professional ability. She felt worried about her language skills. She later reflected on how moving to a different country and "*using a language that is not yours"* can make you feel quite doubtful about your skills, and when someone comments on this, you may feel belittled and mocked and can be a reminder that you come from another country and don't belong in the UK. Similarly, Lily gave an example of feeling ridiculed by a colleague who made remarks about her accent and stereotypical comments about her country.

> *Somebody that I think wanted to be funny, but I think it was a kind of microaggression. This person was high up in the hierarchy and was a consultant. It happened that I would say to this person, good morning and this colleague would reply to me in my mother tongue accent. This person was British and was really posh. So just to be funny or whatever (...) this person would use my accent as a caricature. And I was thinking, you don't have to, it's not funny. Or this person would reply to me in another language. Or, this colleague would tell me all these stories about a friend that was from my birth country, and about food or, you know, kind of quite stereotypical things. And I'm like, you don't have to prove anything. I think this is microaggression.* (Lily)

Lily spoke quite rapidly while talking about this experience, and she conveyed a sense of irritation, frustration, and disappointment.

Longing for integration and acceptance

This subtheme captures the wish of 5 participants to be accepted and integrated in the UK, and their feeling that their accents may impede this integration. The following quotes illustrate the complex dynamics of language, identity and the pursuit of belonging.

Odette highlighted how she wanted to be accepted even though she has an accent. She felt that having an accent could present an obstacle to being accepted.

> *I am kind of anxious in certain situations, and I often think about my accent, so what are people going to think? Do they notice it straightaway? Are they*

> *wondering where I am from? Will they accept me? "I don't want a therapist like this", "I would like to have a different kind of therapist?"* (Odette)

It is important to note that Odette explained that for the first years of living in the UK, she had her own prejudices of being a foreigner. If she did not have a promotion, she would blame her accent, thinking, "*I won't get that promotion after a year because of my accent. They wouldn't promote somebody who has a strong accent, who might not be able to write a report in a perfect English"*" these words encapsulate how she was stigmatising herself for being an immigrant. However, these feelings have changed with time and she is now aware of her abilities. In contrast, Jack explained that he always felt part of the UK, and he embraced the English culture.

> *I've always felt quite assimilated, but the training and seeing patients put things into another perspective, for sure. Culturally, this has been really interesting as I always felt and still do, more country embedded here. So for me, because I first came here when I was 19. And, I really embraced English culture. And I still do to quite a lot of extent.* (Jack)

However, he then explained that his language proficiency fluctuates, especially when he feels attacked or undermined, as seen previously in the sub-theme "Struggle to understand cultural references, idioms, slang, concepts and to express yourself". It is difficult for him to accept that he can, at time, "*struggle with this language",* as the desire to be *"assimilated"* is quite strong. He also said that comments about his English skills have sometimes made him feel patronised as he has "*done four degrees in English, I have done so much".* Similarly, Thea reported from her experience:

> *When I first came to this country, I felt that I really wanted to speak without an accent. I felt like I wanted to maybe renounce to my birth country identity. I don't know why but I didn't want to sound like a foreigner, maybe I just wanted to be integrated. I thought it was important to make an effort and to feel part of the country you're coming to.* (Thea)

Similarly to Jack's experience, the above quote indicates how language is embedded with cultural belonging. In Thea's mind, she could not really be integrated into UK culture as long as she had a foreign accent. With time, she started to wonder whether she would give up her own identity if she got rid of her accent. This sheds light on the challenges of immigration and how it can be hard to feel integrated without renouncing one's culture of origin. Lily also talked about her accent and how she tries not to use her "*strongest accent"* when she goes out with English people.

> *I'm also mindful to not use my strongest mother tongue English accent that I would use when I am with Europeans. I think when I am mixed with Europeans my accent is a bit stronger. When I'm with colleagues and I'm in a group of people that are English, I feel there is a change, not in terms of my accent, but I think I interact less, my capacity to have humour is affected and I feel horrible. I feel like I am an idiot sometimes you know it, because I cannot be spontaneous in English to use my humour in the same way I will use it in my mother tongue. Even more if I don't know the people. With people that I know, and they are British, I can be myself and be funny or whatever. But among colleagues, that they have something in common and they belong to the same country. I feel the outsider. And in a concrete way, it reminds me that, "you don't belong here".* (Lily)

Sarah reflected on experiencing similar feelings when hearing English people talk. She feels jealous of their English and part of her would like to be like them and have their English proficiency, to feel less of an outsider and have more spontaneity in interactions.

> *When I meet English people with such a beautiful English and they know how to express themselves, there's a bit of jealousy that I wish I could have all the sophisticated words or that I will know how to write beautifully, like people that they can really express themselves. I was concern also about working with parents, would they understand me? but also will I be able to impress…mmm…not necessarily impress, but yes also impress them with my knowledge of English? I don't want to make mistakes.* (Sarah)

Regarding feeling accepted, and perhaps integrated, in the UK, Odette talks about how Brexit impacted her and how she may have felt rejected and unwanted in the UK.

> *I just don't identify myself as an immigrant. But certainly when Brexit arrived, I felt like an immigrant suddenly, you know, I had to fill out these forms, and I had to enter my passport, and I needed to ask to stay in this country, I had to ask for settled status. I think my identity was challenged. And also, actually patients were worried thinking about this, there were at least two I can think of, who were worried that I might have to leave.* (Odette)

Surprisingly, Odette was the only participant who mentioned the effect of Brexit on her own identity.

Group experiential theme 4: Therapist sense of self: where do I belong?

This group experiential theme captures participants' perceptions of the self in the realm of different languages and cultures. It also describes the meaning of the mother tongue for the participants. They will be described in greater detail in subthemes "Identity across two different languages and cultures", in which participants describe how relocating into a new country and speaking multiple languages have shaped their identities and "The importance of the mother tongue", in which is revealed how the mother tongue remains a crucial aspect of identity for bilingual therapists.

Overall, this theme captures the multifaceted identities of therapists who navigate multiple languages and cultures, highlighting the deep emotional and psychological impact of their mother tongue and the complexities of belonging.

Identity across two different languages and cultures

In this subtheme, all of the participants described how moving countries and speaking two different languages shaped their identity. Participants described the complex interplay between their native and adopted languages, which influences their sense of self, humour, and cultural belonging.

For instance, Lily explained how speaking two languages and having a connection with two countries impacted on her sense of self.

> *So now, I feel that English has become my second…, I don't want to say mother tongue, but has become almost a mother tongue. I think in a very superficial way I would say I am more myself in my mother tongue. Or in my birth country. Or in London with my friends from my birth country. But also, I am not the same in my*

> *birth country as I used to be, if it makes sense. I have changed, coming here, living here, working here, having psychoanalysis in English, in London. It has changed me. So as if the language has also grown up in me, but I have grown up with it at the same time. So, I'm not the same person in my birth country as I used to be before and the same time it makes me think very often that I don't belong neither in my birth country neither in London now. Where the hell am I? (…) So, it's very confusing.* (Lily)

Here, Lily highlights how belonging to two different countries has made her feel confused about her own identity, at times asking herself, "where do I belong?" Similarly, Odette felt that her personal identity has been shaped by the experience of living in different countries and speaking multiple languages.

> *Mmm. I think there is something about culture, but also about identity. I also wonder if it really matters where you're from. I always saw myself very much as a European, even before I moved to the UK, I always had a strong European identity. So culturally, having lived in different places, having lived in different places in my birth country, having moved to another country and then moved to the UK. So maybe it's a bit tricky sometimes to know what my culture actually is. I have still lived most of my life in my birth country, but obviously my identity has changed massively and what is my culture now? I might be from my birth country, I have a passport from that country. But what does that mean? That's a massive spectrum, isn't it, of something?* (Odette)

Sarah tried to explain how she experiences herself when she speaks English or her mother tongue. She said that when she speaks English, she can "*lose a part of herself"*, explaining that she loses spontaneity and freedom, which particularly affects her sense of humour, as clearly explained in the following vignette:

> *I think that probably I combine the two. But I think there is something about being from my birth country that is, it's not rude, but it's a bit more direct, freer, I think that I just saw some parents and I think some of the jokes that I made, because I spoke with them in my mother tongue, actually not jokes, more comments, linked to the familiarity of where they came from. And I think that I felt more comfortable they will probably understand it. With English people… I'm being a bit extreme now, because through the years, you can integrate. But there is a little bit more needing to … reservation and a little bit more controlled, and I need to think a bit more. But in my mother tongue there is something I think that it's more direct, and also there is less concern about whether they will understand the humour, there is something about familiarity, so you feel a little bit more at ease.* (Sarah)

Similarly, George experienced feeling like something is lost when he speaks in English, and that it is particularly noticeable when it comes to humour.

> *When I speak Latin languages, I think that this is very much in tune with my identity. I had more difficulty in getting used to, you know, really perceive myself as English. (…) I feel more the same when I speak Latin languages. And I also use my hands. And I use my face more, you know, with the sort of expression, which I don't think you can record. But I think yes, something does change when I speak*

> *English. This is not only in the clinical context, but I think my sense of humour. I think my sense of humour is much more in Latin languages and less into the English humour.* (George)

Lily and Odette also shared the experience that their sense of humour was lacking in their second language. Odette explained that it is not just the humour that can be lost but linguistic "*playfulness"*. She also highlighted how humour and playfulness can be important for the young person in sessions, to help them move away from something difficult, or to build a relationship, or to make the therapist feel better.

Thea shows the extent to which language has shaped her own identity when explaining how she can feel like a different person depending on which language she speaks. In fact, she has anglicised her name and is thus called two different names: one in English and another in her mother tongue. Perhaps she felt she had to change her name as she did not want it to be mispronounced, or perhaps having an English name makes her feel more integrated.

> *I suppose the fact that in English, I have been anglicised my name, so I have two names, one in English and one in my mother tongue. I guess the way I talk is different, I find myself using my chords in a way that feels very different. I don't know, it doesn't feel natural. I don't know, maybe something psychosomatic. I find forcing my voice a lot more when I talk in English, whereas when I talk in my mother tongue, it feels more relaxed. And maybe there is something about having to make an effort to actively talk and think. Whereas in my mother tongue words and thoughts come more naturally, I feel I don't have to be so active in linking things up.* (Thea)

Jack described a different experience, feeling that living in the UK and learning English helped him to *"feel more comfortable with his birth identity*". He also referred to English as his *"way out"* and that it gave him "*freedom"*.

> *When you first started the question, my first thought was, I feel complete. English has completed me. I don't know if that makes sense. Also psychoanalysis is part of this. These two languages have completed me. English led me to psychoanalysis, in a way. So, that's why we choose this place because you feel more able to be a bilingual professional person, because there are so many of us around. If I think about the training, in my year, it was half and half.* (Jack)

Jack also talked about psychoanalytic languages and how this language is linked to English, as he learnt psychoanalysis in English. Indeed, the majority of the participants felt that psychoanalysis is linked to English and it is part of their own identity.

The importance of the mother tongue

This subtheme captures how bilingual therapists maintain a profound connection to their native language, which remains crucial to their identity and emotional landscape.

Sarah explained that she wanted to establish a connection with home by using her mother tongue during lectures.

> *When I was in the training, I spoke my mother tongue with another colleague there. I was always going back to my mother tongue in the middle of lectures. So, in the*

> *middle of the Tavistock, I was going back to something more familiar, something that you can hold on to it. So it was kind…, not necessarily gossiping in my mother tongue, but it was going back to something that you feel familiar.* (Sarah)

Sarah described her mother tongue as "*full of* life"' and explained that when she moved to the UK she lost the familiarity that one can have with one's mother tongue, which tends to leave her with a sense of loss.

> *I feel that if it was in my mother tongue, would I then make the connection quicker? Because you don't necessarily need to hear all the words, I feel like you can hear only the beginning of the word and you can already know what will be the end of the word because you're so used to it.* (Sara)

Sarah, Lily and Thea also talked about how, in their own analysis or during sessions with patients, some mother-tongue words would sometimes suddenly come out without them realising that this was happening.

> *And also, it is still there but a little bit less, but still suddenly you want to say something, and "Ah", and I find myself, we speak very quickly, to say suddenly something in my mother tongue like a comment and then I think, "Oh, I hope they didn't get that I suddenly said something in my mother tongue."* (Sarah)

Sarah explained that when this happens, she feels worried that someone might have understood that she spoke in her mother tongue. Conversely, Lily highlighted that when

she has strong feelings, she finds it difficult not to use her mother tongue, as words in her mother tongue come out almost by reflex. Thea wondered if the words in her mother tongue are coming out of the unconscious; that perhaps her unconscious was trying to speak in her mother tongue.

> *I think I've found myself saying something sometimes in my mother tongue, at times it happens that I am talking, you know, sort of flowing, and then suddenly, a word in my mother tongue would come out. (...) Sometimes, I don't even realise that I'm doing it. It comes, and it's like, "oh gosh". (...) Maybe it's the unconscious that is trying to talk in my mother tongue? or I don't know.* (Thea)

In the quote below, George draws attention to his accent:

> *As you can hear I have a very marked foreign accent when I speak English, which means I've been hanging on to my identity somehow, because I would have had plenty of opportunity to learn to say the "the".* (George)

His words illuminate how it was his choice to keep a strong accent, perhaps as a way to hold onto his origins, probably to still feel close to his mother tongue.

Jack relates to his mother tongue in a different way, struggles to speak it daily, feeling more at ease with his second language. Perhaps Jack feels more detached from his mother tongue and birth country.

> *There probably were occasions. But now I struggle more with my mother tongue than I do with English. I mean, I do speak, but I don't speak it daily, my mother tongue. And I don't really think in my mother tongue. I mean, I do go back, but it feels like I go back two decades in some way.* (Jack)

Similarly, Odette reflects on the possibility of going back to her country and how she might struggle, as she feels that by living in another country you can lose some knowledge of your own culture and country, and you can feel like a foreigner in your own country.

> *I would perhaps feel like a foreigner again, I would have to think about certain words, culturally, I'm not aware of my birth country music anymore. I would have to translate again, almost like if I'm being a foreigner in my own country. I often say that I feel I speak two languages badly, now. That's all what happened, in all these years. I think when somebody moves to a different country, and starts to work in a different language, at the beginning you translate a lot, and then comes this point where things just get muddled up, really confusing time, when half of your dreams are in your mother language and in English, all these words, perhaps they come a bit muddled up and then it comes a time when you start perhaps to feel a bit more settled in what's going on, and you work something out, maybe in your dreams at night, and during the day as well, in the way you're talking.* (Odette)

Lily and George both had the experience of working tongue as child and adolescent psychotherapists in their mother, and Lily explained how this was overwhelming.

> *But when I had this parent speaking to me in my own language, within seconds I could feel the whole emotional component of her words and it was really overwhelming for me. Because you know, when you're talking to somebody in your language you can pick up on the tone of voice, the rhythm and everything so I really felt in my bones, the anxiety, the sadness, desperation, everything. And it really impacted on the way I had to call the boundaries, I had to be more detached, because I was really close to her, I could feel what she was feeling. (…) I realised it makes a difference working in your second language. In the sense that I feel much closer when I use my language, whereas now it helps me have a barrier emotionally and this allow to have less impact on me, if it makes sense.* (Lily)

Here, Lily describes how she felt excited about working in her mother tongue, and realised that there are differences between working in her mother tongue and in her second language. She felt that her mother tongue carried an emotional impact, with the words being emotionally charged. She found it difficult to draw emotional boundaries and felt an increased closeness, wondering if she was perhaps too close. George also talked about an experience that he had with a patient in his mother tongue. This girl brought a dream to the session and he could interpret it in a way that he felt he could never have managed in his second language, as he used the double meaning of a word to make the interpretation. In his opinion, it is important to use the patient's mother tongue, as it can evoke more associations.

> *I prefer for the patient to be able to speak his mother tongue, and to have association to dreams, for instance, in his mother tongue. I think, in my experience, when the patient is speaking in the mother tongue, you're more connected with your feelings. And I think your associations are freer.* (George)

Here, George highlights how it is important to use the patient's mother tongue since, in his opinion, it holds more potential to evoke associations.

Conclusions

In this chapter, the complex experiences of bilingual child and adolescent psychotherapists have been explored through four emergent group experiential themes: Navigating cultural and linguistic challenges in therapy, the impact of therapist's foreignness into the transference, coming from another country: the painful journey of immigrant child and adolescent psychotherapists, and therapist's sense of self: where do I belong? These themes collectively provide a comprehensive view of the challenges and benefits involved in providing therapy in a second language, as well as the personal and professional impact of cultural and linguistic diversity.

The group experiential theme 3, coming from another country: the painful journey of immigrant child and adolescent psychotherapists and the group experiential theme 4, therapist's sense of self: where do I belong? can intersect in their exploration of identity, belonging, and the experiences of immigrant therapists, however, they each focus on distinct aspects of these experiences. The group experiential theme 3, emphasises the external challenges and emotional struggles faced by child and adolescent psychotherapists due to their immigrant status. This includes experiences of rejection, attacks on their language skills, and the longing for acceptance and integration into their new professional and cultural environments. The key focus is on the external societal and professional impacts on their sense of belonging and professional identity.

In contrast, the group experiential theme 4, focuses into the internal psychological and emotional experiences of child and adolescent psychotherapists as they navigate their identities across different languages and cultures. This theme explores how participants perceive themselves within the context of their mother tongue and the new languages they adopt, and how these linguistic shifts influence their sense of self and belonging.

The findings focus on the dual aspects of bilingualism and otherness, as these elements are crucial in understanding the lived experiences of participants. Bilingualism is not merely about the ability to speak two languages but involves navigating complex cultural landscapes and the unique therapeutic dynamics that arise from working in a second language. The participants' bilingualism is highlighted as both a challenge and an asset in therapy, influencing their ability to connect with patients and understand cultural differences. Otherness, on the other hand, is explored through the therapists' experiences of being perceived as foreigners due to their language use and cultural backgrounds. This otherness impacts their professional relationships and their own sense of belonging within the new cultural context. It encompasses the external perceptions and biases they encounter and the internal struggles of maintaining their cultural identity while integrating into a new culture. The findings shed light on the multifaceted identities of bilingual therapists and the complex interplay between language, culture, and professional practice. It emphasises the resilience and adaptability of participants as they navigate the challenges of providing therapy in a second language while maintaining their cultural identity and striving for acceptance and belonging in a new cultural environment.

Reflectivity: The researcher as bilingual child and adolescent psychotherapist

Analysing the data, finding the more significative quotes to cite, and writing the findings chapter proved more challenging than anticipated. Indeed, as mentioned above, I experienced a conflict between my role as researcher and my role as bilingual child and adolescent psychotherapist. As a bilingual child and adolescent psychotherapist myself, I am aware that I am bringing my own assumptions to the research study about what it is like to work in one's second language. I believe that my own experience, and discussions with my colleagues and supervisor, have undoubtedly influenced my journey as a researcher, from the choice of research question all the way through to data analysis. Therefore, in order to be as more objective as possible when writing the chapter of the findings, I thought it would be important to cite many quotes so as to accurately report the experiences of the participants. However, my own experience as a bilingual child and adolescent psychotherapist probably impacted on the choice of quotes.

It was exciting to observe the emergence of certain themes as I learned about my participants' experiences. I have also learnt a lot about myself as a bilingual child and adolescent psychotherapist and I believe it is important to share my own experience. While writing, I became more aware of the differences in my identity as bilingual child and adolescent psychotherapist between when I first commenced this project in my second year of training, and now that I am clinically qualified. When I chose this topic, I remember that I was constantly worried about my language skills and that my bilingualism would take something away from the process of therapy. I was hypersensitive to any comments that patients or colleagues could make about me, my nationality, and language. I felt inadequate and not good enough as a therapist. I was also concerned about my writing skills, and I remember that every time I had to present in a supervision group, I would feel anxious about my write-up and use a lot of my

time to check for mistakes. I was surprised to realise that all participants reported having the same experience of anxiety relating to writing skills. Like the study participants, I was worried about not understanding a specific word, but with time I became much more confident about my abilities as a therapist, and I am no longer preoccupied with my language skills.

With time, I also learnt to not get anxious about how to answer when a patient showed curiosity about my nationality, and I realised that every situation is different and needs to be assessed in the moment. I am also less worried about my accent and how it might impact the therapy, and I believe that my being different can support my patients regarding their own differences.

As to my own identity as a bilingual self, I realised that at the beginning of my child psychotherapy career, I felt more split, and like I had two identities, each related to one of the two languages that I was speaking. However, this changed with time, and the longer I spent living and working in the UK, the more integrated my two languages and cultural identities became.

Engaging in this research allowed me to reflect on the experience of working in my second language, while also equipping me with a better understanding and awareness of potential problems that can arise due to a language mismatch.

CHAPTER 5

Discussion

Introduction

This research project has explored the lived experiences of bilingual child and adolescent psychotherapists providing psychotherapy in their second language, especially with monolingual patients. It has placed particular emphasis on child and adolescent psychotherapists' emotional experiences relating to being immigrants; to language-related challenges; experiences of the self across two languages, and to the transference relationship.

In examining the data from the interviews of six bilingual child and adolescent psychotherapists, using IPA, commonalities in their experiences were found and the results illustrated four main group experiential themes, which are: Navigating cultural and linguistic challenges in therapy; the impact of therapist's foreignness into the transference; coming from another country: the painful journey of immigrant child and adolescent psychotherapists; therapist sense of self: where do I belong?

The main results of the research show that language-related challenges were impinging into the transference relationship with patients, but that this challenge decreased as feelings of competence and confidence in conducting therapy in a second language increased. The results also show that being an immigrant child and adolescent psychotherapist can have an impact on the transference as well as on the psychotherapist's own identity, who needs to navigate across two different languages and cultures.

In the following section, each of the four group experiential themes is addressed and discussed in the light of the psychoanalytic and empirical literature on the subject, as described in the

literature review above. As a result of the IPA analysis, in order to address some of the results I had to look for additional literature references to the ones reported in the literature review chapter. Limitations of this study, suggestions for further research, and clinical implications will be addressed at the end of this chapter.

Navigating cultural and linguistic challenges in therapy

The results evidenced participants' challenges of understanding patients or colleagues, not being understood or expressing themselves when working in their second language. This is also explored in Gulina and Dobrolioubova's study (2018), when their participants described the difficulties they would encounter while conducting therapy in a second language, such as understanding the meaning of English proverbs, some words, or jokes. When talking about these challenges, one of the participants of the present research talked about a "*double worry*"; explaining how, generally, the aim of the therapy is to understand the patient and how, if a psychotherapist does not feel able to fully understand the patient, this can bring anxiety in the therapy. Therefore, being from another country and conducting therapy in a second language adds an extra layer of worry which relates more to the psychotherapist than to the patient. The way this particular participant reported feeling is in line with what Flegenheimer (1989) describes when making a similar comparison while exploring the challenges faced by bilingual psychoanalysts.

The majority of participants reported having experienced struggles in understanding cultural references and idioms; in fact, the results demonstrate a strong link between language and culture, which shows that learning a new language is not just about comprehending words and grammar rules but also about understanding societal norms and cultural traditions. This finding is consistent with what Frie (2011) writes about his experience of bilingual therapy, suggesting

that culture and history are—often unconsciously—revealed in the use of language. According to Frie, our self-perception, interaction with others, and perception of the world are all influenced by the culture and cultural background—including language and social customs—which shape us from birth and continue to shape us throughout our lives. Kokaliary et al. (2013) also acknowledged this finding, through participants discussing how culture is deeply embedded in language.

The results also demonstrate that when participants struggle to understand something that the patient has said, they can feel inferior, not good enough, stupid, ignorant, which can affect their confidence. These results are consistent with the findings of Amati-Mehler, Argentieri and Canestri (1993), Akhtar (1995), and Gulina and Dobrolioubova (2018). Most of Gulina and Dobrolioubova's (2018) participants reported feeling inadequate, confused, inexperienced, or incorrect in their English language skills compared to their patients. This perception could lead to a sense of being different and sometimes even inferior, and they also reported a loss of confidence. Also, Ng and Smith (2012) note that limited mastery of the language, and the feeling of not understanding something, can affect the self-confidence of counsellors working in a foreign culture and language.

The findings further illustrate that participants' experiences of not understanding something in therapy can also be used as a tool for not solely focusing on the literal content of patients' words, but to gain insight into the feelings behind the words, and the relational dynamics that are played out by the patient with the therapist. Indeed, two participants took away valuable insights from their, at times, inadequate understanding of their respective patients' words. It allowed them to better understand the struggles their patients were facing. These findings add an additional layer to Gulina and Dobrolioubova's findings (2018). Gulina and Dobrolioubova

reported that one of their participants noted that even when they were unable to comprehend the words in a patient's rambling speech, there is a sense of understanding beyond what is being said, and they also mentioned Reik's (1968) famous metaphor of listening with the "third ear", which refers to a therapist being attuned to the hidden messages in a patient's speech. This notion implies that there are instances in therapy where language is not necessary for effective listening. Instead, therapists can employ their listening skills as a way to access the unconscious and repressed aspects of the patient (Reik, 1968).

The findings revealed that participants, especially at the beginning of their career, would feel quite vulnerable when working in a second language, and this can lead them to self-criticism regarding their language abilities. It appears that participants' own critics may hinder their ability to uncover deeper layers of meaning within therapy. This was also found by Lijtmaer (1999), who explained that challenges linked to language skills can prompt therapists to take a more guarded approach in treatment.

However, one important and highly relevant result is that there appears to be a way for participants to manage the difficulties related to not understanding some words or concepts, or not being understood, which is to rely upon the transference and therapeutic techniques. In addition, the perception of the challenges changes over time, with participants describing that the sense of defeat diminishes as they gain more confidence in their clinical abilities, and feel more acclimatised in the culture. Similar findings were also reported in Dobrolioubova's (2011) unpublished doctoral thesis. The participants in her study expressed the same concerns relating to understanding and being understood, and these difficulties were addressed by seeking clarification, engaging in self-disclosure, and pursuing further exploration.

Additionally, also her participants reported that their sense of comfort and competency increased with practice, feeling less confident at the beginning of their careers.

The impact of therapist's foreignness into the transference

The results indicate that all participants experienced that their patients projected onto their accents or culture. It highlights how the therapist's foreignness and diversity can evoke some feelings in the transference. Patients used their accent or their foreignness to communicate something worrying or scary about themselves that they were unable to accept and that they then projected onto the therapist. The results showed that patients or parents may develop a perception of the therapist as unsafe, untrusting, and unreliable due to the therapist having a different language or culture. This could lead them to believe that the therapist would be unable to truly understand their experiences. These findings seem to confirm Kokaliary et al.'s (2013) reported findings. They explained that one of their participants talked about a patient that attacked the therapist's accent as a way to project unwanted parts of himself onto the therapist. Also, all their participants reported that language differences may trigger issues of trust and hostility. Similarly, Lijtmaer (1999) described how having a therapist with a different native language can stir up mistrust in the therapist, and a fear of not being understood. In Nguyen's (2014) study, findings described that some of the participants had patients that assumed they could not understand them because their therapist was from a different culture and had a different mother tongue.

The present study has also shown how patients try to connect with their foreign-born therapists. Most talked about how some patients wanted to find a way to connect with them by showing curiosity about where they were from, or showing some knowledge about their birth countries. This result is in line with what Nguyen's (2014) findings indicated. The participants of that

study reported noticing their patients making a conscious effort to make connections with them through showing interest in and knowledge about the therapist's native culture or language. The results reveal some of the benefits of having a therapist that conducts therapy in a second language, such as switching the power dynamics in the sessions and helping the patient to have a sense of agency in the therapy, and making the patients feeling more understood in their own differences as also the therapist was different, as well as noting that the use of simple and clear language can be helpful to patients. Some of these benefits were also reported in the literature. In Nguyen's (2014) study, some participants believed that patients that had had the experience of not fitting in may feel less judged by a therapist that has the difference of speaking in a second language. In Costa's (2010) and Medlicott et al.'s (2022) studies, therapists highlighted that speaking in a non-dominant language can shift the power balance within the therapy, and the difference can be used as a tool. One of the participants mentions how it benefitted her to not belong to the English culture in that it made it easier to go into a session without pre-established assumptions, reminds me of Bion's (1967) concept of approaching the patient without memory and desire.

The results illustrate the participants' experiences of using English in their own analysis. None of the studies that I found on the topic explored the experience of the bilingual therapist as a bilingual patient, which makes this the first study that reports on this aspect of being bilingual in our profession. All the participants chose to have analysis in English, for several different reasons, especially to feel more included in the UK. This result was also found in Lewis's (2015) paper, explaining that her foreign patient chose an English-speaking therapist to feel more integrated in America. Conversely, some of the participants in the present study acknowledged that not having analysis in their mother tongue felt like a loss. However, some

explained that it never came to their mind to have analysis in their mother tongue; they did not expand on this.

The majority of participants reported that some words could stir up different associations in different languages and that it was at times difficult to find the right English word to describe their experience and to translate some concepts and idioms or expressions from their mother tongue to their second language. These results seem to confirm the findings of Flegenheimer's (1989) paper, which talked about the experience of psychoanalysts and patients expressing themselves in their respective second language, and how some proverbs and words would become meaningless or take on a different meaning in another language.

The results of this study have added an extra layer to the studies mentioned above, as the participants spoke of how their misunderstandings with their own analysts left them feeling frustrated, resentful, and not understood, which was also how they described their own patients' experiences of feeling not understood by the participants in their roles as therapists.

Finally, the majority of the participants talked about how they would sometimes use words from their mother tongue, as they almost felt as though they came through from the "*unconscious*". This seemed to confirm what Kokaliary et al. (2013) and Lewis (2015) found in their research and clinical experiences, as they explained that in therapy there is sometimes the need to use the mother tongue to express some concepts.

Coming from another country: the painful journey of immigrant child and adolescent psychotherapists

This theme generated results that gave some insight into the complexity of being an immigrant and a non-native English-speaker child and adolescent psychotherapist. The results indicated

that 4 participants had experienced situations with colleagues, supervisors, or parents in which they felt attacked and stigmatised for coming from another country or for their language skills. They talked about feeling discriminated, stigmatised, ridiculed, attacked, and criticised. What emerged was that when the participants experienced feeling attacked or criticised for their language skills, they started to have doubts about their professional and language skills, and these would have an impact on their confidence. This result is in line with what has already been reported in the literature. According to Gutierrez (1982), bilingual clinicians may appear less proficient in their verbal reflections, potentially impacting their self-perception as counsellors. Patients from the dominant culture may hold the belief that bilingual therapists, who have a different mother tongue from them, may not provide effective services. This can lead to therapists being undervalued or disregarded because of assumptions about their proficiency in that language (Comas-Díaz & Jacobsen, 1991; Lijtmaer, 1999). The 2022 study by Peng et al. revealed that therapists who work in a second language experience higher levels of discrimination compared to native English-speaking international therapists. It was discovered that patients often judge the professionalism and counselling competency of international therapists based on their language proficiency, which could impact the therapists' emotional well-being and confidence. Similarly, in another study conducted by Medlicott et al. (2022), participants also expressed feeling patronised, humiliated, and diminished when their differences were used against them.

The results also revealed that the majority of the participants at times felt like outsiders and wished to be accepted and integrated in the UK, with some feeling that their accent could impede this integration. The results demonstrated how it can be hard to feel integrated without renouncing the culture of origin. This was also pointed out by Akthar (1995), who believed that the immigrant may need to temporarily sacrifice some of their individuality in order to

integrate into the new environment. He also wrote that the new language feels like a rebirth; a fresh identity. However, this perception is shattered upon hearing your recorded voice, which sounds unfamiliar, more reminiscent of your old self than the language you're trying to master. Mittal & Weiling (2006) also found that immigrant therapists can often feel like outsiders. Importantly, the above feeling was even more heightened by the political situation surrounding Brexit, with one participant explaining how it had made her feel left out and rejected in the UK.

In addition, the results revealed how the participants felt and were perceived as 'other', due to their different language and cultural backgrounds. This 'otherness' can have an impact on their professional relationships and their own sense of belonging within the new cultural context.

Therapist sense of self: where do I belong?

The results demonstrated that all participants described how moving countries, having a connection with two countries, and speaking two different languages impacted on their sense of self and shaped their identity. One of the participants reported that when speaking English, she would "*lose a part of herself*", including spontaneity and freedom. However, another participant described a different experience, feeling that English helped him to feel freer. Yet another mentioned that she anglicised her name, meaning that she has two different names in two different languages. These findings are consistent with the previous literature. Pérez-Foster (1992) stated that,

> bilingual and bicultural (persons) possess two language codes with which they can think about themselves, express ideas, and interact with the people in their world. This duality is a unique characteristic of bilingual individuals. It is a fundamental factor that affects their lives and must surely impact on how they go about narrating their life story in the treatment process. (p. 5)

and referred to language-related self-experiences (1996, p.102). Other authors refer to this as "hybrid identity" (Akhtar, 1995, p.1) and having "multiple language-based selves" (Walsh, 2014, p. 58). Akhtar (1995) thought that the immigrant lives in two linguistic worlds, pronouncing his own name in two different ways, and switching with relief to his mother tongue once the workday is over, adding to the splitting of self-representations. Gulina and Dobrolioubova's (2018) study participants shared how they would feel like a different person depending on which language they were speaking.

The results revealed how the majority of participants felt that speaking in a second language professionally and personally might affect their sense of humour and linguistic playfulness. In Dobrolioubova's (2011) unpublished doctoral thesis, some participants felt that humour was not as readily available when working in their second language, resulting in the loss of a valuable tool for therapy. Verdinelli and Biever's 2009 study showed that participants utilised humour more often when working in their native language, allowing them to quickly and effectively connect with their patients.

The results showed that, because the participants had their training in second language, they all felt both that psychoanalysis had become linked to English, and that psychoanalysis was part of their identity. Sprowl's (2002) study accorded with this, as the participants who had received their professional training in English reported feeling less confident when conducting interventions in Spanish. They voiced worries about their vocabulary when discussing psychological issues, theories, or interventions in their mother tongue.

The results also demonstrated how the majority of the participants found the mother tongue essential to their identity. They explained how during sessions with patients some words of

their mother tongue would sometimes suddenly come out without them realising it was happening. They wondered whether their unconscious was perhaps trying to speak in the mother tongue. Akhtar (2006) also explored this, discussing the potential for immigrant analysts to feel the urge to intervene in their native language, even when the patient cannot understand the words. It is important for analysts to be mindful of their own emotions regarding their immigration experience and to consider whether there is something in the patient's communication that would trigger this desire to respond in their mother tongue.

In this study, just two participants had the experience of working as child and adolescent psychotherapist in their mother tongue. One of them believed it to be important to use the patient's mother tongue, as in his opinion this is the language that can evoke more associations. Indeed, Costa (2010) wrote that it is generally believed that working in patients' native language is most beneficial for the therapy. Conversely, another participant explained how working in her mother tongue was overwhelming, as she felt emotionally impacted by the words. She found it more difficult to establish emotional boundaries and felt there was an increased closeness. Delboy (2020) reported having the same feeling, that working with a patient in his mother tongue moved him in a unique and profound manner, unlike any of his other patients. For him, it was the first time that a patient opened up about their pain in his own native language. He believed that if he had heard the same narrative and level of emotion expressed in English, his reaction would have been different. Walsh (2014) also elaborated on how, when treating patients in her second language, she could avoid the emotionally charged topics of immigration, feeling lost in translation, and the loss of identity that she had frequently encountered. However, in her mother tongue, she felt the painful identification with her immigrant patients more acutely.

Contribution of this study to the existing literature

From this study, I believe, we gained several new insights. For instance, this research focuses on transference and it showed how the therapists' foreignness and accents were quite important in the transference, evoking different feelings, as patients projected their fears and insecurities onto the therapists developing a perception of the therapist as unsafe, untrusting, and unreliable due to the therapist having a different language or culture. While this could create mistrust, it also provides opportunities for patients to connect with therapists through curiosity about their background, thus shifting the power dynamics and enhancing therapeutic relationships, and he 'otherness' of the therapists could be beneficial to patients who also felt different or marginalised. Furthermore, the transference was seen as a tool to gain more insight about the patients, as the foreignness of the therapist might stir up difficult feelings in patients and can enable these complex feelings to be explored.

This study addresses the emotional impact of being an immigrant, which profoundly influences the therapists' sense of self, and it highlights the heightened vulnerability and self-criticism that therapists often experience. In fact, the challenges that therapists face in understanding cultural references, and idioms and being understood, can impact their confidence. It also highlighted that the own critics of the bilingual therapists can hinder their ability to uncover deeper layers of meaning in the therapy. For this reason, the therapist should be aware of their unresolved grief over their immigrant experience in order to better navigate complexities in the therapy. However, over time, these challenges can decrease as therapists become more comfortable and skilled in their second language. Interestingly, therapists also learned to use misunderstandings as therapeutic tools, focusing on the emotions and relational dynamics behind patients' words.

It is important to mention that is the first study that explores the experience of bilingual child and adolescent psychotherapists, as previous studies focused on therapists working with adult patients. Furthermore, it also gives some insight into the experience of being bilingual therapists that have also been bilingual patients, as being in analysis is part of the training to become a child and adolescent psychotherapist.

The findings suggest that bilingual child and adolescent psychotherapists bring a unique set of skills and perspectives to their work, which can enrich the therapeutic process. However, they also face significant challenges that need to be acknowledged and addressed within the training and professional development frameworks.

Limitations

As previously mentioned, in this study, I had the double role of the researcher and bilingual child and adolescent psychotherapist. This might have encouraged participants to share their experiences, but it may also have hindered the process. This aligns with Leudar and Antaki's (1996) and Yardley's (2000) theory that the listener plays a role in shaping communication through shared identity and understanding. However, as much as I tried to distinguish my role as a researcher from my role as a bilingual child and adolescent psychotherapist, it is possible that my assumptions on the topic might have biased my interpretation of the data.

Another limit, as explained in the methodology chapter, is that the sample is not completely homogeneous, as one of the participants had one parent from the UK, and had therefore been exposed to the English language since babyhood. However, the participant was born in another country and felt that English was their second language, and the experiences reported were quite similar to other participants.

This study, focusing on interviews with 6 bilingual child and adolescent psychotherapists in different stages of their career, produced a range of interesting themes and the experiences and the difficulties described were quite similar between participants. However, due to the small sample size, there is little scope for generalising the data, and it should therefore not be considered to speak for the experiences of all bilingual child and adolescent psychotherapists working in their second language.

Recommendations for future research

A larger sample size is advised in order to gain a more comprehensive understanding of bilingual child and adolescent psychotherapists' experiences of working in their second language, potentially revealing additional aspects of this experience. Furthermore, participants also mentioned how cultural diversity might impact on the therapeutic relationship. Therefore, a next step would involve a more in-depth exploration of the bilingual child and adolescent psychotherapist's experiences of working with patients with a different cultural background. This exploration would not only expand our comprehension of child and adolescent psychotherapists' perspectives but also shed light on the potential obstacles and advantages that may arise due to cultural mismatches.

This research leaves a question unanswered: what can be considered a mother tongue? As explained above, the participant who was exposed to the English language since babyhood did not consider English to be their mother tongue. This left me puzzled with regards to the above question. Future studies could interview bilingual psychotherapists—not just for children and adolescents—that have been raised with two different languages about what they may consider a mother tongue to be.

Implications for clinical practice

The findings of the current study have important implications for clinical practice. In particular, I believe that they can increase awareness of the impact that language and cultural differences can have on therapy. It emerged from the study that the transference can be valuable as a tool in managing issues related to working in a second language. In fact, the results reveal that all participants noticed that their accent and foreignness stirred up difficult feelings in their patients, children and parents. The study demonstrated that patients or their parents might perceive the therapist as unsafe, untrustworthy, and unreliable due to the therapist's different language or cultural background, leading to a belief that the therapist would be incapable of fully understanding their experiences. It is important that child and adolescent psychotherapists are aware of these dynamics as it can help them in their practice.

In addition, this study showed that being an immigrant and working in a second language can evoke persecutory feelings in the participants, as they can identify themselves as being less able compared to native psychotherapists. I believe these results could help psychotherapists to develop a better understanding of themselves and support them in exploring personal issues relating to their bilingual and immigrant selves while working in a second language. In fact, it is important for child and adolescent psychotherapists to be aware of their own unresolved grief over their immigration history and to have a less guarded approach in the therapy and to be able to reflect on their own experience to navigate the complexities that can emerge in the therapy.

Furthermore, psychotherapists facing similar challenges as those revealed in the current study might find these findings helpful in normalising their experiences. The idea that shared experiences and the understanding that confidence and competence improve with practice can serve as a source of motivation for them. As this research also included the point of view of

psychotherapists as patients, talking in their mother tongue in their own analysis, it may enhance the awareness of monolingual psychotherapists regarding cross-lingual and cultural issues in their work with patients who speak more than one language. Additionally, supervisors collaborating with bilingual supervisees may find these findings significant. This study can shed light on some areas for exploration, but also to encourage dialogue about bilingualism and its difficulties in the transference. Additionally, clinical implications include the need for supportive supervision and training programs that address the specific challenges faced by bilingual therapists.

Finally, I believe that these results are important as they can support and inform child and adolescent psychotherapists and the psychotherapy profession more generally about working in a second language. The results can be quite relevant as the UK consists of a lot of migrants from different countries and with different languages, and many UK child and adolescent psychotherapists come from other countries.

CHAPTER 6

Conclusion

This study has explored the lived experiences of bilingual child and adolescent psychotherapists providing psychotherapy in their second language, especially with monolingual patients. In doing so, the research has showed various levels of insight about being immigrants, the own sense of self across two languages, and about transference, all of which participants had gained from working in their second language, using their psychoanalytically-informed clinical practice.

As mentioned in previous chapters, the main results of this research evidenced that language-related challenges might have an impact on the transference relationship, as patients can project into psychotherapists' accents and cultures. However, bilingual child and adolescent psychotherapists become more competent and confident as they gain experience in conducting therapy in their second language, and in using the tool of transference and therapeutic techniques to overcome some language-related challenges in the therapy. In terms of emotional experiences, the majority of participants reported how the therapist's foreignness and diversity can evoke some feelings in the transference, and how they would occasionally feel attacked and stigmatised for coming from another country or for their language skills. They mentioned feeling discriminated, stigmatised, ridiculed, attacked, and criticised. These attacks led to doubts about their professional and language skills, and these would have an impact on their confidence, especially at the beginning of their career. The results also showed the benefits of having a bilingual child and adolescent psychotherapist in the transference relationship.

The literature review described the difficulty I encountered regarding the limited number of existing studies focusing on the experience of bilingual psychotherapists working in their second language, where I could find no study that related the experiences of bilingual child and adolescent psychotherapists working in their second language. There was one exception, which I was unable to get hold of. This study, then, is one of the few reporting on the experiences of bilingual therapists working with children and young people, however, the results are quite similar to those of the studies of therapists working with adult patients. Furthermore, the literature review supported the importance for the therapists to explore personal issues related to their bilingual and immigrant self while working in a second language.

Finally, I believe that my research has contributed to filling a gap in the literature about the lived experiences of bilingual child and adolescent psychotherapists working in their second language. I trust that my findings make a good contribution to, and can increase the awareness of, the impact that language and cultural differences can have on the therapy. Furthermore, psychotherapists facing similar challenges as those revealed in the current study might find these findings helpful in normalising their experiences.

Regarding future research, a larger sample size is advised in order to gain a more comprehensive understanding of bilingual child and adolescent psychotherapists' experiences of working in their second language, potentially revealing additional aspects of their experience.

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Appendix 1: Ethical Approval

The Tavistock and Portman NHS
NHS Foundation Trust

Quality Assurance & Enhancement
Directorate of Education & Training
Tavistock Centre
120 Belsize Lane
London
NW3 5BA
Tel: 020 8938 2699
Fax: 020 7447 3837

Eva Coen

By Email

27 January 2021

Re: Research Ethics Application

Title: What is the experience of bilingual Child and Adolescent Psychotherapists working in their second language? An interpretative phenomenological analysis.

Dear Eva,

I am pleased to inform you that subject to formal ratification by the Trust Research Ethics Committee your application has been approved. This means you can proceed with your research.

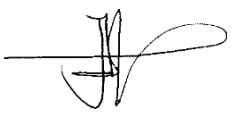
Please be advised that the assessor has added an advisory note for consideration: *Re-read Hollway and Jefferson and the FANI methodology. Discuss the method with your supervisor and rethink your semi-structured interview schedule in light of the methodology.*
Please see attached checklist.

If you have any further questions or require any clarification do not hesitate to

contact me. I am copying this communication to your supervisor.

May I take this opportunity of wishing you every success with your

research. Yours sincerely,



Paru Jeram

Secretary to the Trust Research Degrees
Subcommittee T: 020 938 2699
E: academicquality@tavi-port.nhs.uk

cc. Course Lead, Supervisor

Appendix 2: Research Project Invitation Letter

Surrey and Borders Partnership NHS
NHS Foundation Trust

Children and Young People's Services

Dear colleagues,

I am about to embark on my Doctoral Research Project as part of my Child and Adolescent Psychotherapy training and I am contacting you to seek your support with the recruitment process.

The project title is: ***What is the experience of bilingual Child and Adolescent Psychotherapists working in their second language? An interpretative phenomenological analysis.***

In this context, the word "bilingual" refers to a person who has reached a proficient level in a second language in late adolescence or later.

I am looking to recruit and interview six to eight (for a maximum of 8 interviews) bilingual Child and Adolescent Psychotherapists, who work in their second language and meet the following inclusion criteria:

- have reached a proficient level of competencies in their second language in late adolescence or later.
- with a wide range of length of experience, spanning from trainee to highly experienced (more than 15/20 years of qualified work).

I attached a participant information sheet for your information. Please do not hesitate to get in touch with me if you would like to take part in this research or if you know some of your colleagues that might be interested in taking part in my research study.

Kind regards,

Eva Coen
Child and Adolescent Psychotherapist in Doctoral Training,
Community Child and Adolescent Mental Health Services NW Surrey
Unither House
Curfew Bell Road
Chertsey KT16 9FG
Tel: 01932587066
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Appendix 3: Participant Information Sheet

The Tavistock and Portman
NHS Foundation Trust

Participant Information Sheet

ProfDoc Research Project Title: *What is the experience of bilingual Child and Adolescent Psychotherapists working in their second language? An interpretative phenomenological analysis.*

Thank you for expressing an interest in participating in my qualitative research study which will form part of my professional doctorate. This information sheet describes the study and explains what will be involved if you decide to take part.

Who am I?
My name is Eva Coen and I am a Child and Adolescent Psychotherapist in Doctoral Training at The Tavistock and Portman NHS Foundation Trust employed at Surrey and Borders NHS Foundation Trust. The training is validated by Essex University.

What is the purpose of this study?
As part of this study, I want to explore the experiences of bilingual Child and Adolescent Psychotherapists conducting therapy in their second language. In this context, the word "bilingual" refers to a person who has reached a proficient level in a second language in late adolescence or later. The two languages have been learnt in separate environments and have been associated with different contexts. As the use of a second language is also connected with the fact of being an immigrant and thus not belonging to the dominant group, I am interested in exploring the emotions and feelings of Child and Adolescent Psychotherapists from minority cultures working in their second language with monolingual patients from the dominant culture.

What will participating in the research involve?
If you decide to participate to this project, I will invite you for a face-to-face interview. The interview will last between 60 to 75 minutes and will take place at a time and day convenient to you. The interviews will be audio-recorded using a voice recorder. In the context of the COVID-19 crisis, it may be necessary that the interview is conducted via telephone or Zoom

video conference rather than in person, and this is also an option open to you if it would be more convenient.

Do I have to take part?
No, taking part in the study is completely voluntary. If you agree to take part, you can withdraw without giving any reason at any time up to two weeks after the interview has taken place. This timescale has been decided as the data will then being processed and analysed. If you decide to withdraw all data collected or about you will be destroyed immediately.

What will happen to what I say at the interview?
The interviews will be audio-recorded using a voice recorder which I will use to playback and transcribe in full at which point the recording will be destroyed by recording over. I will anonymise and analyse your transcript in order to complete the write-up of the research study.

Your name and personal details will be stored separately from the transcript in accordance with the University of Essex Data Protection Policy and the General Data Protection Regulations 2018. This means that all electronic data will be digitally encrypted and stored on a password protected computer which only I will have access to. Any paper copies will be kept in a locked filing cabinet in my office. All data will be destroyed no later than three years after the study has been written up for academic submission.

How will my data be protected?
This research study has received formal approval from the Tavistock and Portman Trust Ethics Committee (TREC). These processes ensure I conduct the study within legal and ethical standards.

If you have any concerns or queries regarding my conduct you may contact Simon Carrington, Head of Academic Governance and Quality Assurance, Tavistock and Portman NHS Foundation Trust (academicquality@tavi-port.nhs.uk).

General Data Protection Regulation (2018) arrangements
The Tavistock and Portman NHS Foundation Trust is the sponsor for this study based in the United Kingdom. I will be using information from you in order to undertake this study and will act as the data controller for this study. This means that I am responsible for looking after your information and using it properly. I will keep identifiable information about you from this study for three years after the study has finished.

Your rights to access, change or move your information are limited, as I need to manage your information in specific ways in order for the research to be reliable and accurate. To safeguard your rights, I will use the minimum personally identifiable information possible. I will use your name and the contact details you provide only to contact you about the research study. I am the

only person who will have access to information that identifies you. I may be assisted in the analysis of this information by senior colleagues, but they will not be able to identify you and will not be able to find out your name or contact details.

You can find out more about the legal framework within which your information will be processed by contacting the sponsoring Trust's Clinical Governance and Quality Manager, Irene Henderson: IHenderson@tavi-port.nhs.uk

Confidentiality
It is important for you to know that I would not use your real name in the paper. During the interview, I would ask you to disguise the identity of patients and to avoid using details of cases that would be recognizable.

Although I would use pseudonyms, there is a possibility that due to the size of the study, you or the location of the study could be identifiable. However, the patients you discuss in the interview would be completely unidentifiable. I would encourage you to contact me (see details below) at any point prior to or following the interview to discuss any concerns about confidentiality. In order to guard against the risk of you being identified, I will consult with you to ensure you are fully informed about the proposed use of data and I will share the extracts from your interview used in the write up of the study with you prior to academic submission to ensure that you are comfortable and aware of what potential risks of identification may result from publication.

What will happen to the results of the project?
The results will be used in my thesis for the professional doctorate, in published academic papers and in academic presentations.

What are the possible benefits of taking part in this research?
I believe that your participation in this study will provide a significant contribution to knowledge in this otherwise neglected area of study. It is hoped that it will provide a space for you to consider and reflect on your experience in a way that may be helpful for future work.

Are there any risks?
The interview is not likely to be upsetting. However, you may find that the interviews get you thinking about yourself and this may stir up some difficult emotions and be unsettling. However, you can stop the interview at any time and I would aim to conduct the interview with the utmost sensitivity and non-judgemental respect for the strong feelings that can be stirred up. In case of any upset or concerns that may arise through the interview process, I will endeavour to make myself available for follow-up conversations and I will provide to all participants the details of sources of support.

Contact details

I am the main contact for this project. My contact details are:

Eva Coen
Email: Eva.Coen@sabp.nhs.uk
Child and Adolescent Psychotherapist in Doctoral Training,
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Curfew Bell Road
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You are welcome to contact my research supervisor: Dr Lucia Genesoni
luciagenesoni@gmail.com

Appendix 4: Consent Form

The Tavistock and Portman
NHS Foundation Trust

Participant Consent Form

ProfDoc Research Project Title: *What is the experience of bilingual Child and Adolescent Psychotherapists working in their second language? An interpretative phenomenological analysis.*

Name of the Researcher: Eva Coen

Please put your initials in the boxes on the right below:

I_____voluntarily agree to participate in this research project.	
I confirm that I have read and understood the information sheet for the above study, version 1 dated 14 November 2020. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	
I understand that my participation in this study is voluntary and that I am free to withdraw, without giving a reason, at any time up to two weeks after the completion of the interview	
I understand that the interview will be recorded and transcribed as described in the participant information sheet.	
I understand that all data which I contribute will be destroyed no later than 3 years after the study has been written up.	

I understand that my name and personal information linked to my participation in this project will be anonymised and held securely by the researcher.	
I understand, whilst every effort will be made to anonymise the interview that I provide, that it is possible that quotes used in the final piece of work might be recognisable to myself.	
I understand that it is my responsibility to anonymise any examples referring to cases I chose to discuss during the interview.	
I understand that the results of this research will be published in the form of a Doctoral Research Thesis and that they may also be used in future academic presentations and publications.	
I understand that being interviewed might involve some risk of emotional upset or discomfort and that I can stop the interview at any time.	
I understand that after the interview I will be offered time, if needed, to talk about how I feel.	
I confirm that I have understood all of the above and what is required of me. I consent to participate in this study.	

Participant's Name (Printed): _____

Participant's signature: _____ Date: _____

Contact details:

Researcher: Eva Coen Email: Eva.Coen@sabp.nhs.uk

Supervisor: Dr Lucia Genesoni Email: luciagenesoni@gmail.com

Thank you for agreeing to take part in this study. Your contribution is very much appreciated.

Appendix 5: Indicative Interview Schedule

The Tavistock and Portman
NHS Foundation Trust

Indicative Interview Schedule

ProfDoc Research Project Title: *What is the experience of bilingual Child and Adolescent Psychotherapists working in their second language? An interpretative phenomenological analysis.*

Name of the Researcher: Eva Coen

Welcome: explanation of it being a semi-structured interview lasting between 60 and 75 minutes. Remind them that they are welcome to talk freely about their experiences of being a bilingual Child and Adolescent Psychotherapist working in a second language. Explain that they can discuss specific cases (past and present) that may feel relevant. They can request to take a break or stop at any time if they find it hard to answer some questions.

At the beginning of the interview I will ask some sociodemographic information, such as: Age, the languages they can speak, when they reached a proficient level in the second language, if they are trainees or qualified Child and Adolescent Psychotherapists and how many years of experience they have.

Themes and possible prompts:

1. **What is your experience of conducting therapy in your second language?**
   Possible prompts:
   - Can you tell me whether your linguistic and cultural identity have influenced your professional identity and development? How? in which ways?
   - Can you think of some examples?

2. **What are in your opinion the language-related challenges and benefits? How these may impact on the therapy and the therapeutic alliance?**
   Possible prompts:
   - Do you feel you can share where you are from with patients?
   - Can you tell me your experience of times in which you might not know a word used by your patient? What do you do? If the patients use metaphors, proverbs,

idioms, humour and slang that you don't know, how do you react? How do you feel?
- Have you felt that patient engagement or attendance levels have been influenced by issues around language?
- Do you feel you that at times you might experience some challenges in fully expressing yourself?
- How do you think your patients and parents react to your accent and pronunciation?

3. **What are your thoughts and feelings about the transference relationship and the use of countertransference when working in a second language?**
   Possible prompts:
   - How is it to make interpretation in your second language?
   - Do you want to give me any examples?
   - How do you use your therapist's bilingual self in transference and countertransference?

4. **What is your experience in your own personal analysis? Which language do you use?**

5. **Can you tell me how do you feel about your own self when you talk in a different language and in your mother tongue?**

6. **Do you have the experience of conducting therapy in your mother tongue?**
   Possible prompts:
   - Can you compare the experiences between working in your mother tongue and your second language?

7. **Is there anything I did not ask that you would like to mention?**

Thank them for taking part

Appendix 6: Debrief Letter

The Tavistock and Portman
NHS Foundation Trust

Version 1, 14.11.2020

Dear….

I am writing to thank you for your contribution to my Doctoral Research Project.

I hope that through your invaluable contribution, this study will help to enhance understandings of the experience of bilingual Child and Adolescent Psychotherapists working in their second language. Additionally, I hope your valued contribution will provide valuable insight to practitioners working in their second language.

If following taking part there are any issues that are concerning you, you can contact me at the contact details provided below. Additionally, if you would like to speak with someone, please do contact The Association of Child Psychotherapists, who will help or signpost you:

By telephone: 020 7922 7751

By email: admin@childpsychotherapy.org.uk

By post: The Association of Child Psychotherapists, CAN Borough, 7-14 Great Dover Street, London, SE1 4YR

If you have any concerns about my conduct over the course of this interview or any other aspect of this research study, please feel free to come in touch with me (eva.coen@sabp.nhs.uk), my Research Supervisor Dr Lucia Genesoni (luciagenesoni@gmail.com) or Simon Carrington, Head of Academic Governance and Quality Assurance, Tavistock and Portman NHS Foundation Trust (academicquality@tavi-port.nhs.uk).

Kind regards,

Eva Coen
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Community Child and Adolescent Mental Health Services NW Surrey
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Appendix 7: Exploratory Notes and Experiential Statements

Experiential Statements	Original Transcript	Exploratory Notes
Difficulties with using humour Difficulties with understanding cultural references - Culture embedded in the language Difficulties with understanding the meaning of some words Feeling insecure Learning to be part of UK culture through the work Feeling more acclimatised with the new culture Feeling closer to the UK culture through the work Feeling excited (about working in mother tongue)	**Me:** Do you think knowing a second language and being of different culture can have an impact on your therapeutic relationship? **456:** Yes, because I think also on your question later, I still struggle with humour or with cultural references that adolescents use. Or even the more kind of middle class or upper middle-class patients, they use very particular vocabulary that I try to know the word sometimes, but I kind of pick it up from the whole sentence. It's really interesting, because mmm let me think. **Me:** If you have any examples will be great. **456:** I don't think it has an impact on the patients. I learned through the work how it is to be in Britain, if it makes sense. And it helps me kind of not to adjust, but to be part of this culture. Because also my friends, some of my friends are from my birth country, some others are British. So working with British young people, it also kind of brings me closer to their culture and not to the generation yet. I have an example with parent work. I have worked with different parents in English and I had only one in which we talked in my mother tongue, because the parent was from my birth country and when we talked I	Struggle with humour or with cultural references used by adolescents, or with the vocabulary used by upper/middle class patients. *Uncertain tone of voice. Thinking.* Learning trough the work to be part of UK culture. Working with British young people brings the participant closer to the UK culture. Example of working in mother tongue. Big difference working in mother tongue. *Excitement in the tone of voice.*

Realisation of the differences between working in your mother tongue and in your second language Being in touch with different range of emotions (working in mother tongue) Emotional impact /emotionally charged Overwhelming feelings (linked to working in mother tongue) In mother tongue you can pick up more emotional clues Difficulty putting emotional boundaries (in mother tongue)	realized, oh my goodness, that's a difference. **Me:** And that was the first patient you had in your mother tongue? **456:** That was the only and first and last so far experience I had in my mother tongue. Because before that, I thought that actually it is okay to not work in your first language as you know I can understand them, I can pick up the emotional. But when I had this parent speaking to me in my own language, within seconds I could feel the whole emotional component of the words and it was really overwhelming for me. Because you know, when you're talking to somebody in your language you can pick up on the tone of voice, the rhythm and everything so I really felt in my bones, the anxiety, the sadness, desperation, everything. And it really impacted on the way I had to call the boundaries, I had to be more detached, because I was really close to this parent, I could feel what the parent was feeling. And it also happened that the parent was from the same part of my birth country I am from, so you know, there was too much in common. And so that was when I realized it makes a difference to work in your second language. **Me:** Difference in what sense? **456:** In the sense that I feel much closer when I use my	This is the only experience working as a therapist, in mother tongue. Realising of the difference between working in mother tongue and in second language. In mother tongue, you can feel the emotional component in the words (picking up from tone of voice and rhythm), linking this with overwhelming feelings. Difficulty to put emotional boundaries in mother tongue. It is too close. Using English, the participant puts an

Putting an emotional barrier (with second language)	language, whereas now it helps me have a barrier emotionally and this allow to have less impact on me, if it makes sense. **Me:** So, if you speak English, you feel you put a barrier.	emotional barrier. Less emotional impact on the participant.
In mother tongue: increased closeness – too close?	**456:** Yes, it has less emotional impact on me in a way than it has in my mother tongue. This is how I experience it.	With the mother tongue the participant feels closer.
Struggling of using mother tongue professionally Mastery of the language is linked to clinical experience Psychoanalytic language linked to second language (the language you trained)	**456:** And also I couldn't speak in my mother tongue in terms of using some words because I have no idea of my mother tongue terminology for mental health. So, while I was talking to the parent, I needed to pause and I had to think to what to say. And I also realized that I had developed a professional language in English, not in my mother tongue. **Me:** I understand, thank you. I wanted to ask you about your analysis. In which language is your analysis?	Struggling of using mother tongue related to the mental health terminology. Professional language is in English. Psychoanalytic language is in English.
Personal analysis	**456:** In English **Me:** How did you find it? Did you want an English analyst?	Personal analysis is in English.
Wish of improve mastery in second language Wish of being more part of the culture (by choosing an English analyst) With second language you can put an emotional barrier Emotional charged material	**456:** Yes, I chose an English analyst, to be honest, just for me to learn, and also to learn to speak psychoanalytical language in English. But also, much later I realized, that actually, it's again a kind of a barrier, because, let's say the word hate or love in English, I can easily say them, you know, but if I had an analyst	It was a choice of wanting to have the analysis in English. To be able to learn more the psychoanalytic language in English. Later, realisation that using English in personal analysis is putting an emotional barrier. Some words are

(mother tongue) Emotional words are easy to be used in second language as they are less emotionally charged	from my birth country, I don't know if I could use the same words, not directly to the analyst, but generally, you know, I am talking about the emotional component, they're emotionally heavy. It's more difficult to use them in your language, I think. **Me:** Of course, and do you use your mother tongue sometimes in your analysis? **456:** If it slips for my mouth? **Me:** Yes. Or if you need to explain something that perhaps in English is more complicated or if you don't have the words.	easily to say in a second language than in a mother tongue.
Feeling frustrated with the analyst as not feeling understood completely (linked to language and culture) Can you understand me if you don't know? Fear of not being understood Lost in translation Something is lost when you are not from the same culture (by explaining something)	**456:** Yes. So, I think, you know, sometimes I can get a bit upset or frustrated, like, 'if you were from my birth country now, you would know what I mean'. Or, you know if I gave you this explanation, you would understand perfectly fine what it means for our culture, or what happens in my birth country. And so, I have to explain to my analyst phrases that either I don't know in English or don't exist in English, and I need to translate them concretely and directly. They don't make sense and then I have to explain them, which makes the work a bit funny and fun, actually. But yeah, I don't know, if your analyst is from a different culture, how much can they pick up on the culture.	Expressing some frustration about participant's analyst as the analyst does not speak the participant's mother tongue. Can the analyst really understand the participant? Perhaps an analyst with same mother tongue and culture will understand better. Uncertainty about the fact if the analyst can pick up on the culture or not. Translating some concepts from mother tongue to second language is not easy as sometimes do not make sense. *While the participant is talking about this, puts a lot of emphasis.*

Appendix 8: Table of Personal Experiential Themes of One Participant

Managing difficulties and perception of difficulties over time
Initial difficulties – moving to UK and starting to work as a CP
Felling more confident and secure can be linked to be more acclimatised with the new culture and language and to clinical experience
Insecurity about language is linked with professional experience
Something foreigner

Therapist's sense of self – Identity formed through different languages
Holding on your origins/culture
Experience of self in the realm of different languages
The professional self in mother tongue and second language
Sense of humour

Importance of the mother tongue
Mother tongue language of the emotions
In mother tongue: increased in sharpness
Loss of something
Wish of the therapist talking same mother tongue of the patient – something is missing or lost (ex with mother not mother tongue English)

The therapist as a patient (experience of personal analysis)
Personal analysis (both analyst and patient talking their second language)
Experience of not feeling understood - Misunderstandings can bring distrust in the therapy
Feeling resentful linked to not be understood
Associations are different in different languages
Can you understand me if you don't know?

Psychoanalytic tools and therapeutic relationship
It is what the patient projects into the accent
Use of the therapist bilingual self in the transference relationship (making interpretations)
Language used as negative transference. ('other' language and culture of the therapist used for negative transference (patient-therapist relationship)
Transference dynamics not always connected with language
Language and cultural background as part of the therapeutic relationship
The experience of the therapist of being perceived as different and ridiculed/attacked (by patient as being ridiculed for a mistake related to language)

Understanding the patient and making yourself understood
Struggle to understand cultural references and 'meaning of the language' (slang, quotations, literature references and the meaning of some words)
Inadequacy (anxiety?) of the therapist linked to not knowing or not understanding (Feeling: guilty, insecure, ashamed, ignorant) (countertransference?)
Expressing yourself (in second language)
Patients feeling resentful or not understood if something important is not known or not understood (maybe patients feeling not contained)