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Editor's Note: For the interested reader, an outline of the structure of the case study of "Mary" is shown in Appendix 1.

Language Use as Both Bridge and Barrier in Bilingual Therapy: A Single Case Study Analysis of the Chinese International College Student, "Mary"

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ABSTRACT

Psychologists often encounter clients from varied language and cultural backgrounds, which can pose challenges to the process of helping. The case of "Mary," an unmarried, 24-year-old Chinese international student in the U.S., embodies these dynamics and offers insights into how culture and language shape, and are shaped by, the therapy alliance, process, and outcome in bilingual therapy. Mary was seen in individual therapy that combined a multicultural, relational psychodynamic, humanistic, client-centered, and solution-focused approach by one of the authors (Y.X.) for 10 sessions (over a 14-week period, with four cancellations); and the therapy was supervised by the other author (J.N.F.). Mary's presenting problems included challenges in adjusting to her new environment, including a decline in self-confidence and difficulties in her social life, which led to significant anxiety in her daily life.

To enhance understanding of the course of therapy, we employed an adapted version of the Critical Incidents Technique (CIT) to analyze significant moments in Mary's 10 sessions. We focus on the role of language use in bilingual therapy, exploring its functionality as both (a) a buffer against the intense impact of emotional and traumatic experiences, and (b) as a bridge that can foster deeper psychological engagement. We highlight the mechanisms by which the therapist, with supervision, attempted to provide Mary with a meaningful and helpful psychotherapeutic experience. The core theme in our analysis of the case includes the ways that Mary uses her primary (Mandarin) and secondary (English) languages to avoid, and then access, hurtful and traumatic experiences.

Keywords: Bilingual therapy; language use; psychological defense; therapeutic alliance; Critical Incidents Technique (CIT); clinical case study; case study

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1. CASE CONTEXT AND METHOD

"Mary," a 24-year-old Chinese cisgender heterosexual female graduate student, sought weekly psychotherapy at a university counseling center in the U.S. Her initial presenting problems included anxiety, lack of self-confidence, insecurity about her language skills, and difficulties socializing. Mary expressed excessive worry about her English proficiency, fearing that professors and students would not understand her. In class, she avoided speaking up and, when required to do so, experienced panic accompanied by physical symptoms such as sweating, nervousness, and racing heart. She lacked confidence in academic settings, often second guessing her answers and worrying they might be incorrect, which she feared could lead to ridicule from peers or professors. Socially, Mary avoided interactions with classmates unless they were Chinese students with whom she could speak Mandarin. She also avoided social settings requiring communication in English, isolating herself and reinforcing her lack of confidence in language skills. The therapy involved a combined a multicultural, relational psychodynamic, humanistic, client-centered, and solution-focused approach. Mary speaks Mandarin as her first language and English as her second language. Over 10 sessions (over a 14-week period, with four cancellations), Mary engaged in individual therapy, which was conducted remotely via Zoom. The availability of free sessions for international students at her current university, coupled with encouragement from her mentor, motivated her to seek therapy.

The co-author (Y.X.) was the therapist treating Mary. Y.X. is a Chinese cisgender heterosexual female, who came to the US as an international student from China 11 years ago and spoke English fluently, albeit as a second language. At the time of treating Mary, Y.X. was in her third year of a clinical psychology doctoral program and was undertaking clinical training as an extern in the university counseling center. The supervisor (the first author, J.N.F.) is a Latino cisgender heterosexual male, an immigrant to the U.S. who also learned English as a second language. At the time of the therapy, he had had 25 years of experience as a licensed psychologist, professor, and clinical supervisor within the United States.

Process notes were utilized after each session throughout the treatment, and these notes were signed by the supervisor to ensure treatment efficacy and monitor progress, as well as manage any potential risks. The last three psychotherapy sessions, as well as the follow-up session, were recorded and transcribed. Weekly supervision sessions were held to discuss the case and develop treatment approaches for future sessions.

In this case study, we focus on the role of language use in bilingual therapy, exploring its functionality both as a sort of defense mechanism, buffering against the intense impact of emotional and traumatic experiences, and as a bridge, fostering access to memories and possible psychological insight. We will also demonstrate the mechanisms by which the client and the therapist (along with supervision) can work toward a deeper and more complete psychological

experience when the client uses L1 (the first language) and L2 (the second language) capacities to avoid, and then access, hurtful and traumatic experiences.

2. THE CLIENT

Mary is an unmarried, 24-year-old Chinese cisgender heterosexual female graduate student. She sought weekly psychotherapy at a university counseling center in the U.S. with a few presenting problems. Mary reported challenges in adjusting to her new environment, including a decline in self-confidence and difficulties in her social life, which led to significant anxiety in her daily life. While she had successfully formed connections with other Chinese international students in New York, she acknowledged facing challenges in building friendships with people from other cultural backgrounds.

2. GUIDING CONCEPTION WITH RESEARCH AND CLINICAL EXPERIENCE SUPPORT

The Role of a Client's Bilinguality in Psychotherapy

Bilingual speakers are defined by psycholinguists as people who can speak two languages. They do not necessarily have to be equally skilled in both languages, as language proficiency is more of a spectrum than a clear-cut yes or no. The languages a bilingual person uses are often referred as L1 (the first language or mother tongue) and L2 (the second learned language). Sometimes, L2 becomes the one they use more in their daily life, while L1 is used less. Bilingualism can happen in different ways. Some people learn both languages at the same time from birth, which is known as simultaneous bilingualism. Others learn their first language and then pick up a second language during childhood, which is called early sequential bilingualism. There is also late sequential bilingualism, where someone learns a second language as a teenager or even later (Ramoo, 2021). In the United States, approximately 67.8 million individuals are bilingual, representing a substantial segment of the population. This figure constitutes approximately 22.0% of the U.S. population, underlining the significant prevalence of bilingualism in the country (Dietrich & Hernandez, 2022).

Based on data from the 2023 American Community Survey, the United States Census Bureau has reported the predominant languages spoken at home other than English as Spanish, spoken by 41.3 million people and constituting 13.2% of the U.S. population. Additionally, Chinese languages, encompassing Mandarin, Cantonese, and other dialects, are spoken by 3.4 million individuals, accounting for 1.1% of the U.S. population.

This demographic presentation underscores the growing need for bilingual therapy services (Guilman, 2015; Kelson et al., 2022). Bilingual therapy, which involves the use of a language other than English by therapists and/or clients, is common in many communities where people either speak limited English or speak English fluently but prefer to also speak another

language (Gallardo-Cooper, 2008; Seto & Forth, 2020). Although precise statistics on the proportion of bilingual therapy sessions within the wider scope of therapeutic practices are not currently available, the importance of such services is undeniable. A survey conducted by the American Psychological Association in 2016 revealed that approximately 10.8% of psychologists in the U.S. were equipped to offer services in languages other than English (Phillips, 2021). Considering the substantial bilingual community in the United States, the absence of detailed statistical information does not diminish the significance of bilingual therapy as an essential focus for both research and practical application in the field of psychotherapy.

In bilingual psychotherapy, two key linguistic phenomena often observed are language-switching and language-mixing. Language-switching refers to the practice of alternating between two or more languages within a single conversation or even within a single sentence. This can occur when bilingual individuals switch languages between L1 and L2 to better express certain thoughts or emotions that they feel are more accurately or comfortably conveyed in one language over another (Williams et al., 2020). Language-mixing involves the blending of elements from different languages, such as using words, phrases, or grammatical structures from one language while predominantly speaking in another (Ezeh et al., 2022).

Language-switching and language-mixing in therapy sessions can provide insights into a client's emotional and psychological state (Alhamami, 2019; Cieślicka & Guerrero, 2023; Ladegaard, 2018; Verkerk et al., 2023). For example, individuals may choose to use their first language (L1) when delving into deeply personal or emotional subjects, indicating a stronger emotional connection with that language. Panicacci and Dewaele (2023) investigated this phenomenon in a study with 468 migrants proficient in Italian as L1 and English as L2. Their findings revealed that the use of L1 to articulate emotions not only heightened the participants' sense of their feelings but also intensified the emotional experience. People might also employ language-mixing as a strategy to mitigate the emotional impact of discussing traumatic events (Verkerk et al., 2021; Xia et al., 2022).

In a study conducted by Marian and Kaushanskaya (2008), 47 Russian-English bilinguals were asked to recount their immigration experiences in either Russian or English, according to their own preference. The results showed that participants used their L2, English, more frequently than their L1, Russian, when describing the negative emotions associated with their immigration experiences. This study suggests that when coping with strong emotions, people might tend to use their L2 to avoid confronting difficult emotions. Of course, this depends on individual language proficiency, but it indicates that bilinguals' expression of emotion may vary across languages.

Language choice serves as a tool in navigating, and at times, avoiding traumatic experiences in psychotherapy (Busch & McNamara, 2020). Even within monolingual therapy

settings, clients frequently utilize linguistic defense mechanisms while discussing or attempting to access traumatic memories. These mechanisms include intellectualization, characterized by a detached, analytical discussion of trauma (Middleton et al., 2022); minimization, where the severity of trauma is understated (Monti et al., 2021); and attribution, involving the shifting or reassigning of blame (Pinciotti & Orcutt, 2019). Such strategies often result in talking around about trauma rather than direct addressing, sometimes leading to the rationalization of traumatic experiences to make them seem less distressing.

In bilingual therapy contexts, the choice of L1 or L2 used to narrate events, along with language-switching and mixing, can serve as indicators for therapists. These linguistic choices may suggest that clients are experiencing intense emotions. Bailey et al. (2019) examined this phenomenon in a study involving adolescent immigrants who narrated events triggering their migration to the U.S. in either their first L1 or L2. The findings indicated that narratives in L1 contained significantly more expressions of anger, whereas those in L2 featured more mentions of positive emotions. Thus, therapists' attentiveness to these language choices and shifts can be invaluable, offering clues to the hidden emotional landscapes of clients and guiding the therapeutic approach to address these deeply embedded traumatic experiences.

However, language in therapy should not be viewed solely as a barrier. In bilingual therapy, language switching and mixing can be strategically utilized to facilitate the exploration of memories and emotions, potentially having a significant impact on the therapeutic alliance and outcomes (Kapasi & Melluish, 2015). The ability of both the client and the therapist to communicate in more than one language not only enriches the therapeutic session but, when employed effectively, can also act as a powerful catalyst for improved therapeutic work and outcomes. In a study by Cook and Dewaele (2021), interviews with refugees who had survived sexual persecution revealed that using the survivors' L2 enabled them to express traumatic experiences more freely. Speaking in L2 provided a sense of liberation and empowerment, allowing them to discuss trauma that would be difficult to articulate in their L1, ultimately leading to greater self-acceptance. In this context, language switching became a 'bridge,' enabling clients to reconnect with their past experiences. The use of L2 created a 'new space' for therapy, which might not have been as accessible if conversations were limited to L1. As clients developed a sense of safety and the therapeutic alliance strengthened, either the therapist or the clients could suggest transitioning to their L1. This shift often took place when the traumatic experiences became perceived as less intimidating, which in turn could further enable deeper and more effective therapy work.

In exploring the psychological functions of language in therapy, especially concerning bilingual individuals, Fuertes (2004) sheds light on the dynamics of language coding and mixing in supervision contexts involving bilingual supervisees. He observes that such linguistic

strategies often serve as defense mechanisms for supervisees, and by extension, therapy clients, to momentarily withdraw from emotionally charged material.

Fuertes notes that bilingual individuals may switch from their native language to second language, ostensibly as a means to distance themselves from discussing experiences that occurred when they were using their L1. Discussing L1 experiences in L2 is hypothesized to provide a safer, less emotionally charged space, making discussion possible, but limiting the emotional intensity that would be experienced in L1: in essence, L2 allows clients to address topics that would be too painful or embarrassing to confront in their first language. In this way, the second language acts not just as a barrier but as a bridge—facilitating the discussion of difficult issues from a more detached, yet safer emotional perspective.

The linguistic shift enables clients to share experiences that they might otherwise be unable or unwilling to express. Fuertes' insights highlight the other role of language in bilingual therapeutic settings, where the choice of language itself becomes a bridge in facilitating the complexities of emotional and psychological exploration. The strategic use of L1 or L2 can render therapy more approachable for some clients, facilitating the therapeutic process at tolerable levels of anxiety by allowing individuals to express themselves within comfortable emotional boundaries. However, for therapy to be deeper and more comprehensive, it may be necessary for the therapist to challenge and encourage clients to explore how they might be using language strategically to avoid fully engaging with the depth and breadth of their experiences. The strategic shift from L2 to L1 to L2 and so on may be conscious or unconscious. Therefore, the careful yet sustained inquiry into the use of language whether switching, mixing, or exclusive L2, can be clinically indicated, as such inquiry can help to uncover deeper layers of the experience and reflection, leading to more profound therapeutic gains.

The use of language-switching and language-mixing likely also plays a role in helping clients navigate their cultural identities. This is particularly relevant for immigrants, who often prefer bilingual communication rather than single language to better convey their cultural backgrounds (Ali, 2023). Language-switching and language-mixing strategies enable self-expression (Masna, 2020) and can foster engagement and participation in therapy, which are vital for therapists to understand the client's concerns and problems within their narratives (Ng & Zayts-Spence, 2023). Therapist understanding in turn significantly influences both the development of the therapeutic alliance and treatment outcome (Finsrud et al., 2022; Szoke et al., 2019; Villalobos et al., 2016).

Language choice in therapy is not simply a matter of communication, but a strategic tool that profoundly influences emotional processing, psychological thinking, and feelings (Costa et al., 2017; Del Maschio et al., 2022; Kircanski et al., 2012; Nook, 2023). For instance, the use of emotion words in a language does more than communicate emotions; it actively shapes

emotional perceptions and experiences during speech (Lindquist et al., 2015). Gonzalez (2019) highlights that conducting therapy in a client's non-native language can hinder emotional processing, but integrating bilingualism and ethnic identity into treatment enhances emotional processing and strengthens the therapeutic alliance. Language can act as a gateway to unlocking deeply encoded memories and emotions (Baumeister et al., 2017), a protective mechanism to navigate intense feelings (Husain et al., 2023), and a medium for expressing and reshaping personal narratives (Marx et al., 2017). In sum, client/patient language use can represent both challenges and opportunities to a therapist offering bilingual treatment.

The Theoretical Orientation Employed in Mary's Therapy and Its Connection to Mary's and the Therapist's Bilinguality

The therapy combined a multicultural, relational psychodynamic, humanistic, client-centered, and solution-focused approach, carefully chosen to suit with both the therapist's (Y.X.) and Mary's cultural and linguistic backgrounds, as well as her presenting issues. A multicultural perspective was essential, as both Mary and the therapist were Chinese international students studying in the U.S., with English as their second language. This shared background allowed the therapist to better understand Mary's unique challenges, including her insecurity about language skills and difficulties socializing in an English-speaking environment. Respect for Mary's cultural and linguistic preferences was embedded in the therapeutic process, with the therapist allowing her to choose her preferred language during sessions. While Mary opted to speak English, the reasons behind this choice were initially unclear. The therapist respected her decision, remaining sensitive to potential underlying factors such as a desire to improve her English proficiency or adapt to her academic environment. Additionally, the therapist considered cultural factors, such as the importance of academic success and the potential stigma surrounding mental health in Mary's cultural context, promoting empathy and validating her experiences. Liu (2019) emphasizes that culturally rooted values, such as achievement and humility, can be both sources of emotional distress and drivers of personal growth. This perspective suggests the value of exploring how cultural values influence emotional well-being in therapy, particularly when working with clients from Asian backgrounds.

The relational psychodynamic approach provided a space for Mary to freely associate, exploring her memories, emotions, and relational experiences in a safe, nonjudgmental environment. This helped her process intense feelings of anxiety and insecurity related to her language skills and fear of judgment in academic and social settings. The client-centered approach emphasized Mary's autonomy and her active role in the therapeutic process, creating a supportive environment that respected her preferences and validated her decisions. Unconditional positive regard and empathic understanding further built her confidence and agency. The solution-focused orientation complemented these approaches by providing Mary

with practical resources, such as introducing her to university services like the writing center and career center, to help address her academic needs and career development as an international student. Together, these approaches addressed Mary's presenting issues holistically, ensuring that her cultural and linguistic needs were met while empowering her to navigate her challenges.

4. ASSESSMENT OF THE CLIENT'S PROBLEMS, GOALS, STRENGTHS, AND HISTORY

Presenting Problems

As mentioned above, Mary is an unmarried, 24-year-old Chinese cisgender heterosexual female graduate student. She sought weekly psychotherapy at a university counseling center in the U.S. with a few presenting problems. Mary reported challenges in adjusting to her new environment, including a decline in self-confidence and difficulties in her social life, which led to significant anxiety in her daily life. While she had successfully formed connections with other Chinese international students in New York, she acknowledged facing challenges in building friendships with people from other cultural backgrounds.

Background

Mary is from Chengdu in southern China. Being an only child, Mary shared a strong and close-knit bond with her parents, especially her mother, who she considered not just a parent but also a close friend. Despite not being as close to her father due to his demanding work commitments, he provided financial support for Mary's education. Mary described her family background as warm, caring, and supportive.

Mary reported a relatively "typical normal life" in Chengdu prior to moving to the U.S. Her academic performance was consistently above average, and she reported no significant difficulties either academically or socially. In 2021, with a desire to broaden her horizons and experience different educational systems, Mary decided to apply for master's programs in the USA, a decision that was fully endorsed by her parents.

Mary had relocated from China to pursue a master's degree in information system management, starting her program in September 2022. Early in 2023, Mary self-referred to weekly psychotherapy sessions at a counseling center in a university in a highly urban city in the Northeast of the USA.

At the time treatment began, she was enrolled full-time and resided off-campus with roommates. She shared her living space with two roommates, who, like her, are Chinese international students. As she looked ahead, following her upcoming graduation in May 2023, Mary planned to secure employment in the United States and work under Optional Practical Training (OPT)—a program that allows international students to work in the USA in their field of study for up to three years post-graduation. This working period under OPT would provide

Mary with valuable professional experience and help her make a more informed decision about her future steps.

Mary always presented herself in a well-kept manner and was punctual for her therapy sessions. She denied previous psychological treatment, medication usage, or hospitalization, and there was no reported family history of mental health issues. Mary reported no previous romantic relationships.

Mary reported challenges in adjusting to her new environment, including a decline in self-confidence and difficulties in her social life, which led to significant anxiety in her daily life. While she had successfully formed connections with other Chinese international students in New York, she acknowledged facing challenges in building friendships with people from other cultural backgrounds.

Measures Used in Quantitative Assessment

Our assessment of Mary incorporated five standardized scales and two unstandardized questions to quantitatively measure various psychological and behavioral dimensions. The seven measures were selected based on their relevance to Mary's case and her background as an Asian international student. The measures fall into two categories. Four of the measures were symptom-related scales and were chosen specifically because they assess issues that are most commonly reported within this population, as supported by existing literature. These include challenges such as anxiety, adjustment difficulties, and social identity and adjustment difficulties, which correspond closely to Mary's qualitative report of her presenting concerns.

The other three measures assess variables associated with Mary's motivation to engage in therapy in an American setting. These include the client's acculturation to U.S. culture, attitude towards seeking therapy, and the extent of their knowledge about mental health issues.

Each of the measures is described below. Concerning how to interpret the results on these measures, note that, as is discussed below, important aspects of the clinical process in Mary's case was (a) the fact that both she and the therapist were bilingual, with their first language being Chinese and their second language being English; and (b) the fact that both languages were employed at different points in the therapy. As emerged in the clinical process, Mary was more comfortable talking about emotions and emotionally related memories and situations in Chinese than in English. This was important to take into account when interpreting the quantitative measures, shown in Table 1—since all of these measures were in English and were normed, when indicated, on English-speaking subjects.

Measures of Symptoms

The Depression Anxiety Stress Scales-21 (DASS-21). This 21-item scale measures distress across three axes—depression, anxiety, and stress (Henry & Crawford, 2005).

Distress Rating. This consisted of a single question asked of the client: "On a scale of 1-10, rate how distressed are you by this issue?"

Main Issue. This consisted of a single question asked of the client: "What do you feel is the major issue you would like to see change as a result of therapy?"

The Athens Insomnia Scale (AIS). This scale was guided by the International Classification of Diseases (ICD-10) criteria. The scale assesses the severity of insomnia through an 8-item measure focusing on various aspects of sleep difficulties (Soldatos, 2000).

Measures of Motivation to Engage in Therapy in an American Setting

The Asian American Multidimensional Acculturation Scale-Culture of Origin Scale (AAMAS-CO). This 15-item scale (Chung, 2004) was employed to assess cultural acculturation levels, particularly in cultural identity, language, cultural knowledge, and food consumption, with scores indicating the degree of cultural assimilation.

The Attitudes Toward Seeking Professional Psychological Help Scale (ATSP). This is a 29-item scale that explores an individual's attitudes towards seeking professional help and their openness about mental health issues, reflecting on the variables of personal need recognition and stigma tolerance (Fischer & Turner, 1970; Elhai et al., 2008).

The Mental Health Knowledge Schedule (MAKS). The Mental Health Knowledge Schedule (MAKS) is a 12-item psychological measure developed to assess and track mental health-related knowledge, particularly stigma-related knowledge, among the general public. It is designed to evaluate the effectiveness of anti-stigma interventions and programs (Li, Duan, Zhong, et al., 2021).

Quantitative Results Before The First Session of Therapy

Measures of Symptoms

Based on the data from Table 1 before the first session, Mary reported relatively little distress as reflected in low scores on DASS-21 and the Distress Rating, and in the vague, intellectualized statement on the Main Issue item of "Overall Mental Health." These results conflict with the distress Mary expressed in her first session, suggesting that these items—because they were in English and normed in English, and were outside of the immediate therapy relationship – elicited a suppression of Mary's distress.

The main exception to Mary's report of little distress on the quantitative measures was her score on the insomnia scale (AIS), which at 6 was at the clinical cutoff. What is distinctive about the insomnia scale is that it taps into behaviors rather than feelings.

Measures of Motivation to Engage in Therapy in an American Setting

All three measures of motivation were on the high side, reflecting Mary's strong motivation for therapy. Specifically, Mary's acculturation score on the AAMAS-CO scale was solidly in the middle of the scale; her attitudes towards seeking psychological help on the ATSPPH scale were above the cut-off point for other clients; and her knowledge of mental health on the MAKS scale was well above the cut-off point for other clients.

5. FORMULATION AND TREATMENT PLAN

Initial Formulation and Treatment Plan

Initially, the case was conceptualized within the framework of acculturation and adjustment difficulties, commonly experienced by international students adapting to a new cultural environment (Xu, 2024). These challenges were particularly evidenced by Mary's difficulties with English language proficiency observed during the first session, which appeared to be a major barrier to her cultural and academic adjustment.

The therapeutic strategy initially adopted a psychoeducational approach, informed by the triadic model proposed by Xu (2023), emphasizing cultural understanding within the therapeutic setting, service accessibility, and mental health knowledge as key influences on the psychotherapy experiences of Chinese international students. As the therapist (Y.X.), sharing a similar background as an international student from China, I aimed to utilize this commonality to build rapport and offer psychoeducation about anxiety and available resources. This was seen as a foundational step to establish a strong therapeutic alliance. I also offered Mary support for her anxiety regarding speaking English and navigating social situations; however, as the case evolved, both I and the supervisor (J.N.F.) grew increasingly focused on the dynamics of Mary's language choice in therapy, suspecting it might be masking deeper psychological experiences.

Modifications in the Treatment Plan

As therapy progressed, the focus shifted significantly from the initial conceptualization. Language proficiency, initially seen as a mere symptom of acculturation difficulties, emerged as a central theme in Mary's experience of anxiety. Despite the therapist's offer to conduct sessions in Mandarin, their shared first language, Mary opted to continue in English, expressing that it allowed her to articulate her thoughts and feelings more freely, despite noticeable discrepancies between her perceived ease of expression and her actual language proficiency. Mary's refusal to switch to Mandarin, despite her challenges speaking English, and her insistence on addressing her anxiety, procrastination, and lack of self-confidence in English began to concern the therapist

and supervisor, who sensed that her use of English might be a strategic psychological operation, put up to avoid deeper engagement in therapy.

The Use of the Critical Incidents Technique (CIT)

As part of ongoing formulation and treatment planning, we adapted a variation of the Critical Incidents Technique (CIT) to systematically examine significant moments within each therapy session that had a profound impact on the therapeutic direction and outcome (Woolsey, 1986). The CIT enabled us to develop an understanding of the client's dynamics, of how specific incidents influenced the client's progress and the therapist's interventions, and to examine the development of the therapy relationship and the trajectory of the work through the sessions. The therapist maintained copious notes throughout treatment, and with the client's permission video recorded the last three sessions on therapy, as well as post-treatment follow up session.

The analysis of each session proceeded as follows: First, we identified the Critical Incident (CI), which is the event or interaction deemed significant for its impact on the therapy's trajectory. This involved detailing the incident itself, emphasizing its relevance and implications within the therapeutic context. Following this, we moved onto Processing the Critical Incident (PCI), where the incident was examined and interpreted considering the therapist's reflections as well as discussions during clinical supervision. This phase allowed for a deeper understanding of the incident, and how it influenced the therapists' responses as well as the flow and direction of therapy. The Critical Response (CR) outlines the therapist's response to the critical incident. This includes changes in interventions to address the incident. Table 2 presents a summary of each session's Critical Incident (CI), the Processing of each Critical Incident (PCI), and the Critical Response (CR).

6. COURSE OF THERAPY

Sessions 1-4

In the first six sessions Mary spoke English, although her comfort level and ability to use English seemed to diminish with each session. Mary's insistence on using English for communication, despite her noticeable struggles with the language and the therapist's twice-offered option to switch to Mandarin, emerged as a slightly odd preference. Mary communicated that speaking English would allow her to communicate emotions and thoughts more feely, which signaled to the therapist and supervisor that speaking in Mandaring about her problems was more difficult, despite the therapist being fluent in Mandarin.

Although it was still unclear at this point what Mary aimed to gain from using English for the sessions, as the therapist I provided support Mary's preference for English, using it as a therapeutic tool to explore her experiences of anxiety, and to pay more attention in future

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sessions to language use. The decision to embrace Mary's language preference as a cornerstone of the therapeutic process aimed to validate and respect her choices, and to help build an alliance.

Mary also indicated in the first session that she was anxious about her professors judging her English use, and the therapist understood this concern and she also has an accent. Therefore, both I and my supervisor decided to respect Mary's language choice as a way of helping her develop further confidence with speaking English. By closely aligning the therapy with Mary's expressed needs and preferences, the expectation was to foster a stronger therapeutic alliance.

Mary continued to express common concerns that are prevalent among international students, such anxiety related to her performance in academic writing assignments and a desire to improve her confidence with English communication. I introduced the client to on-campus writing tutor resources, which the client was previously unaware of and expressed the intent to utilize. She also expressed concerns with securing a summer internship and fear of being discriminated against due to her being Chinese.

A unique and more distressing moment came when she shared a recent experience of significant anxiety about visiting Chipotle, a fast-food chain that she was keen to try but had never visited; she was anxious about having to order in English fearing others would notice her accent and limited English-speaking ability and being judged as "stupid" and an outsider. She conveyed a very real fear of judgement and humiliation from placing her order.

It appeared to both me and my supervisor, both ESL speakers, that Mary's anxiety and anticipated humiliation represented more than a normative apprehension to speak English. Both of us were struck by what appeared to be Mary's underlying dread of somehow being shamed or humiliated.

During the fourth session, Mary revealed a fear of speaking up in class, tied to concerns about being perceived as unintelligent due to her accent and limited English proficiency. She noted how this fear was linked to the humiliating experiences in classes in China. It became apparent to both me and my supervisor that Mary's anxiety about speaking English in class was tied to stressful experiences with authoritarian teachers in China. This link suggested that Mary's classroom anxiety was not merely about a concern with language use; it appeared to be rooted in trauma experienced *while speaking Mandarin* in China. Mary's pursuit of increased language mastery and comfort with English and her fear of being judged, represented on the one hand a viable way of gaining comfort and confidence in expressing herself in English. On the other hand, her insistence on speaking English began to appear as an indication of previous trauma.

The supervisor and I began to think that speaking English in sessions could aid Mary in making progress when discussing her anxiety and trauma. However, given her limited proficiency in English, it might also restrict the depth of her exchanges with the therapist. It seemed essential to allow Mary to speak English, thereby boosting her confidence in self-

expression and forging a strong alliance with the therapist. This approach, we hoped, could later serve as a foundation to encourage exchanges in Mandarin.

Sessions 5-6

Beginning in session 5, challenges in communication and in using English increased, with Mary frequently struggling to understand me and experiencing anxiety when attempting to express herself in English. This difficulty in finding the right words added layers of complexity to the therapeutic dialogue. A significant portion of the session was characterized by efforts to bridge the language barrier, with my often seeking clarification to ensure understanding, and Mary endeavoring to grasp my open-ended questions.

The session focused more on overcoming linguistic hurdles, detracting from time that could have been spent on more substantive therapeutic work. The language barrier not only impeded smooth communication but also contributed to visible frustration on both sides. Both Mary and I were frustrated with this process, and I made efforts to remain empathic and supportive of Mary.

My supervisor prompted a reconsideration of the underlying dynamics of Mary's insistence on using English, and acknowledging the complexity of the situation, I resolved to gently explore the reasons behind Mary's preference for English. My supervisor suggested that I add Mandarin words to English sentences as a way of testing Mary's reaction to these words. This strategy was to maintain a supportive environment that respected Mary's preference for speaking English while also trying to open discussions about the role of language in limiting the content discussed and the flow and depth of these conversations. We were aiming to increase L1 and L2 mixing and switching.

Mary discussed her ongoing struggles with self-confidence, particularly in social interactions and academic settings involving English speakers. In my role as the therapist, drawing on my personal experiences as an international student from China, I offered empathy and validation of Mary's experiences. This shared background enabled a deeper connection and understanding, reinforcing the therapeutic alliance. My decision to incorporate Mandarin words and phrases, based on suggestions from supervision, aimed to gently probe Mary's language preference without imposing change. Despite this attempt, Mary remained committed to communicating only in English, showing indifference towards the Mandarin introductions.

This pattern of behavior prompted me to inquire directly about Mary's preference for English, leading to Mary's revelation that speaking about embarrassing topics in English was easier for her, as it provided a buffer against experiencing negative emotions:

> I think speaking in English is easier for me to express certain things. If I speak in Mandarin, some things are too embarrassing for me to talk about in the session.

After disclosing her choice to speak English rather than Mandarin in the session, Mary looked pensively away from the computer screen for a moment, then again looked at the zoom screen and said that she would continue discussing things at the next session, without mentioning a possible language change.

Both I and the supervisor had a hunch that Mary used English as a way to mitigate the emotional impact of discussing sensitive topics. This was essentially confirmed by Mary; and both of us believed that this insight into Mary's language use emerged from my patience, the strategic build-up of a strong therapeutic alliance, and the timing of the intervention to explore language preference. Mary's admission underscored the complexity of language in the therapeutic context, not merely as a tool for communication but as a significant factor influencing emotional regulation and depth of engagement.

At this point in the treatment, i.e., sessions 5-6, the therapy seemed to arrive at a critical juncture. The question for me and the supervisor seemed to be whether therapy would proceed as a discussion around the periphery of some issues associated with Mary's confidence and comfort in using English, or would the therapy gain new depth by having Mary attempt to engage in therapy in her native Mandarin? We decided to proceed with the latter, sensing that Mary would benefit from being challenged to speak in Mandarin, and that she might even be waiting for such an approach from the therapist.

Therefore, prior to session 6, it was decided in supervision that the therapist would delicately explore and challenge Mary's language choice in future sessions. The objective was to help Mary explore how her insistence on using only English was probably limiting her work in therapy, and that by switching to Mandarin, even part of the time, would facilitate communication and enhance her therapy experience.

Cancellation of Two Sessions after Session 6

A few days after session 6, Mary informed me via email that she would need to cancel the next two sessions due to conflicts with her midterm exam schedule. While the stated reason for these cancellations was academic commitments, I contemplated whether the preceding session's discussion about language switching/mixing might have contributed to Mary feeling a sense of vulnerability or risk, leading her to seek some distance from the therapy.

I emailed Mary, conveying empathy and understanding, but encouraging Mary to return to the next session; and Mary returned after two weeks. This return was interpreted as another significant milestone in her therapeutic journey, indicating her readiness to continue the work, if anything to process any feelings or thoughts regarding language use and emotional comfort.

Session 7

Mary started session 7 by discussing in English some challenges with school, and before the therapist could inquire about the two-week absence, Mary suddenly shifted to speaking Mandarin—this was while reflecting on her educational experiences in China, specifically mentioning the term "Gaokao" (the college entry exam in China). Mary, now speaking Mandarin, indicated that during the period of the "Gaokao," she had not felt supported by her family. This led to a reflection on her family dynamics. Mary mentioned that although she had described a very close relationship with her mother during the therapy intake, despite their strong bond, she acknowledged the difficulty in voicing disagreements with her while growing up. Mary saw her mother as a "stubborn" person.

I recognized the importance of this shift in language and immediately adapted, conducting the remainder of the session in Mandarin. Acknowledging the depth of conversation achieved in Mandarin, I explored Mary's feelings about using her native language in therapy. Mary remarked,

> It feels okay today because the topic is not embarrassing. I still cannot talk about embarrassing topics in Mandarin yet.

In supervision I reflected on Mary's shift in language use, which she thought to be a manifestation of the client's growing confidence within the therapeutic alliance. Over the previous sessions, my patience and understanding likely contributed to creating a safe and supportive environment. This foundation appeared to have empowered Mary to express more profound emotions and thoughts in Mandarin, a language in which she might experience these feelings more intensely, after I had essentially challenged Mary on the use of English the session before.

The change suggested that Mary felt sufficiently secure to allow the therapist closer to her internal world, facilitated by the stronger bond they had developed. The shift to Mandarin brought forth a deeper level of introspection and engagement from Mary, underscoring the intrinsic connection between language, memory, and emotional expression. This transition not only facilitated a richer exploration of significant topics but also served as a testament to the therapeutic relationship's strength and the client's trust in the therapist. Mary was able to discuss for the first time the less than rosy aspects of growing up with her mom, which she shared included feeling powerless at times, and feeling unloved and unwanted.

Session 8

I was now conceptualizing Mary's case more as involving the exploration of feelings of hurt and resentment as well as feelings of shame and inadequacy instilled by her mother's

treatment. Mary began the session 8 by speaking in Mandarin and did not speak English again in the treatment.

She raised the issue of recognizing her tendency to compare herself to others, usually ending feeling inferior with whoever she made the comparison. Mary reflected on the differences in education between China and the USA since her arrival in the United States. While she acknowledged that American culture encourages individuality and uniqueness, these concepts triggered anxiety within her.

To illustrate her point, she shared a personal example. She recounted purchasing clothes online that didn't fit and needing to return them at the USPS. The thought of going to the USPS to return the items caused her anxiety and embarrassment. She expressed concerns about being judged by others and feeling like she was "taking advantage" of the return policy. This experience brought back a memory from her childhood. She remembered how, as a child, she had to ask her teacher for permission to use the bathroom during class, and the teacher shamed her in front of class for doing so.

Reflecting on these memories, Mary acknowledged experiencing a deep sense of shame at various instances during her childhood. As the session approached its end, I asked Mary how she felt when speaking in Mandarin. She responded, saying,

> It's the same as the last session. I feel comfortable because the topics we discuss are not as embarrassing as others. I need more time to address other things.

Toward the end of session 8, I reminded Mary that the sessions would come to end with the end of the semester. Mary expressed that time "had flown by" and she wondered if there was any way she could continue her therapy sessions with me, as she felt she was just starting to reach the most important part of the treatment. She sensed that something significant and helpful would emerge soon in the sessions.

I acknowledged Mary's appreciation for the sessions but replied that center policy would not allow her to continue to treat Mary beyond the end of the semester. Mary seemed disappointed but responded somewhat dejectedly with an "ok". I reminded Mary that she could continue in therapy at the counseling center as part of a group, but not in individual treatment. I also offered Mary to find a good referral for continued treatment outside the counseling center if she desired to continue in therapy with another therapist.

Mary's acknowledgment at the end of the session that there were "other things" to address in therapy—signified a recognition of her own progress and the therapeutic work ahead. Mary's complete shift to Mandarin revealed the dynamic outlined by Fuertes (2004) where language is believed to serve dual roles—both as a buffer against and a bridge to accessing painful emotions and memories.

Mary's transition to L1 facilitated a deeper level of psychological engagement, allowing Mary to access and discuss painful memories that occurred in the native language, and to process emotions which would otherwise remain shielded when using L2. The discussion in session about Mary's anxiety about returning items and her childhood experiences of shame provided insights into her internalized feelings of inadequacy and guilt. These feelings, as analyzed through a psychoanalytic lens, suggested a deep-seated sense of not being "good enough," possibly stemming from her relationship with her mother. The psychoanalytic perspective offered a view of Mary's mother as an authoritative figure whose harsh criticisms, though undoubtedly rooted in love and reflecting some cultural traditions, contributed to Mary's insecurities and self-doubt.

Session 9

In the 9th session, Mary stated that a renewed curiosity about her early educational experiences in China and her relationship with authority figures as a child. She asked her mother about her childhood experiences between the 8th and 9th sessions. Her mother recounted that when Mary was in elementary school, something might have happened one afternoon at school, which led Mary to start showing fear towards her teachers and struggle with attending school. However, Mary's mother never discovered exactly what had occurred, and Mary did not recall any specific incident. Nonetheless, Mary did remember the significant fear she had as a child towards authoritative teachers and her fear of potential punishment.

Mary re-iterated her distinct sense of relief and ease when speaking her mind in Mandarin. She described—speaking in Mandarin—feeling able to express her thoughts and engage in more meaningful conversations with me using her native language, finding this shift surprisingly helpful:

> It's been very helpful. Before, I didn't know what kind of feelings I was experiencing, but now I am beginning to understand. It has become clearer. The sessions are effective, I can understand a lot about myself. I didn't feel this way at the beginning of the treatment, but now I find it very, very interesting.

Mary's reflections on the educational differences between China and the U.S., particularly the authoritarian versus authoritative roles of teachers, opened a broader conversation about cultural norms and the impact of authoritative figures on Mary's sense of self. The authoritarian educational environment in China, contrasted with Mary's experiences in the U.S., provided a backdrop for understanding Mary's feelings of inadequacy.

Additionally, Mary's relationship with her mother, characterized by criticality and high expectations, could be seen as another layer of her struggle with inadequacy. Her mother's authoritarian demeanor instilled fear and anxiety in Mary, likely contributing to her sense of powerlessness. Mary internalized a narrative of inadequacy and developed an insecure self-

concept. Mary's aspiration to become more "Americanized" revealed a desire for cultural and psychological liberation. This ambition reflected a reaction against the repressive aspects of her upbringing and the authoritarian elements, as she experienced them, in her cultural background.

Mary's push for individualization and movement away from certain cultural norms suggested a form of psychological pushback against her mother's expectations and the pervasive sense that she experienced growing up toward conformity. This aspect of Mary's narrative underscored the tensions between cultural identity, family dynamics, and personal autonomy, which were crucial in understanding her struggles.

Exploring Mary's relationship with her mother appeared to be a vehicle for understanding her struggles, her identity, family relations and dynamics, and her quest for greater autonomy, which seemed to converge around that relationship.

Session 10, The Last Session

In the last session, Mary expressed a realization that her actions were often driven by concerns about how others perceived her, particularly her teachers. She frequently worried about not being viewed as "good" in the eyes of others and was especially anxious about being perceived as stingy.

Mary shared an experience from her middle school years that she considered "extremely embarrassing." During her time in middle school, the client's family did not possess significant wealth. While her peers owned iPhones, she did not have a phone until the final year of middle school. She had pleaded with her mother to buy her a phone, and she did, but it was a less expensive brand, not an iPhone. When some of her peers discovered that her phone was not expensive, they laughed at her. Mary felt intense embarrassment as a result. In a particularly vulnerable moment, while spending time with a boy she liked, who came from a wealthy family, she had felt too ashamed to admit that she owned an inexpensive phone. Instead, she lied and claimed not to have any phone at all.

Mary revealed that this experience had been so embarrassing that she had avoided thinking about it for years until now. I helped her discuss and process some of these feelings, which were clearly painful and difficult to share. The memory involving the boy was not merely about the material object itself but what it represented—being perceived as "less than" by her peers and by herself. This one exchange, shared as a single incident but probably representative of many other interactions for Mary with her peers, mother, and teachers, highlighted Mary's chronic and enduring sense of not being good enough, of not being accepted, and of being inferior. I reflected Mary's feelings, both her pain and shame, but also her strength and resilience. I also reinforced Mary's attempts at deeper understanding, greater self-acceptance, and self-compassion.

After Session 10

Mary had to cancel the next session due to feeling unwell. A week later she requested to re-schedule. I reminded her that the end of the semester had arrived, and that no more sessions could be scheduled,. However, I did ask Mary about possibly meeting for a last time to terminate and say goodbye. Mary did not respond, and on another follow up did not respond to my offering a referral. Although both Mary and I were aware that the treatment would be short-term, it was disappointing that the sessions had to end just as Mary was delving into deeper aspects of her experiences.

7. THERAPY MONITORING AND USE OF FEEDBACK INFORMATION

As mentioned above in the context section, process notes were utilized after each session throughout the treatment, and these notes were signed by the supervisor to ensure treatment efficacy and monitor progress, as well as manage any potential risks. The last three psychotherapy sessions, as well as the follow-up session, were recorded and transcribed. Weekly supervision sessions were held to discuss the case and develop treatment approaches for future sessions.

8. CONCLUDING EVALUATION OF THE THERAPY'S PROCESS AND OUTCOME

Quantitative Outcome

Measures of Symptoms

Some of the therapy outcomes for Mary, as reflected in the quantitative data from Table 1, show a complex but meaningful picture of her progress. From pre-therapy to post-therapy, several notable changes occurred. The DASS scores remained unchanged immediately after the last session, suggesting that her depression, anxiety, and stress levels had not significantly improved in the short term, although they were low in the first place as described above in the assessment section. However, at the six-month follow-up, her DASS total score increased to 20, with specific increases in depression and stress. This change could reflect a resurgence of these symptoms over time, possibly due to ongoing academic and social stressors. Alternatively, the increase might also indicate greater self-awareness and a willingness to acknowledge her emotional distress, which is consistent with her improved ability to reflect and express her feelings during therapy. This highlights the importance of viewing quantitative data alongside qualitative insights, as Mary communicated that therapy was helpful and motivated her to continue seeking support.

Mary's low Distress Rating of 2 at baseline suggests mild symptoms, although it may also indicate limited self-awareness or defensiveness in acknowledging her struggles. Over time, therapy appeared to help Mary gain greater self-awareness and openness to identifying and addressing more specific challenges. This is evident from the post-session identification of her Main Issue as "easily feel embarrassed," with a Distress Rating of 7. Compared to her initial goal, this is a more targeted and concrete concern, indicating that the therapeutic process helped Mary identify specific areas of difficulty. The increase in distress level from 2 to 7 suggests that Mary was in the process of emotional disclosure and facing her struggles more directly. This intensified experience, facilitated by speaking Mandarin during later sessions, likely allowed Mary to explore her emotions more deeply and connect with a more vulnerable part of herself.

At the six-month follow-up, Mary identified "do things I want to do" as her Main Issue, with a reduced Distress Rating of 3. This shift suggests that therapy (or perhaps other factors between therapy and follow-up) had helped her progress from focusing on interpersonal discomfort (e.g., embarrassment) to broader personal goals and self-efficacy. The decrease in the Distress Rating indicates that Mary had made strides in addressing the emotional intensity associated with her earlier concerns and was now more focused on achieving practical and aspirational goals. This shift in Mary's Main Issue, along with the reduction in distress, shows her progress in addressing emotions and turning her attention toward personal growth and autonomy.

Mary's AIS insomnia score demonstrated significant improvement in sleep quality, dropping from 6 at baseline to 0 post-therapy. This shows that the current treatment was effective in addressing her immediate sleep issues, which may have been related to her anxiety and stress. At the six-month follow-up, her AIS score increased to 4, reflecting a mild recurrence of sleep disturbances, although improved from baseline and still below the clinical cut-off. This suggests that what Mary gained from therapy supported her ability to manage her insomnia over time, but ongoing stressors may have continued to affect her sleep.

Measures of Motivation to Engage in Therapy in an American Setting

Mary's acculturation score on the AAMAS-CO showed a decrease immediately post-therapy, which may have been influenced by the topics explored during the later sessions, such as humiliation and shame related to her experiences in China. However, by the six-month follow-up, her score increased, indicating greater cultural adjustment and possibly a better integration of her bicultural identity. This demonstrates the effectiveness of the therapy's multicultural approach, from conceptualization to treatment course, in validating Mary's cultural background while helping her navigate the academic and social challenges faced by international students in the United States.

Mary's attitudes towards seeking help on the ATSPPH scores showed a steady increase, reflecting a growing positive attitude toward seeking professional psychological help. This change suggests that Mary became more open to the therapeutic process and developed trust in professional support. By the six-month follow-up, her score had increased further, indicating sustained growth in her willingness to engage in mental health services, which is a significant positive outcome for a first-time therapy client with initial hesitations.

Mary's mental health knowledge (MAKS) scores were high initially and remained relatively stable, with a slight increase post-therapy and consistent scores at the six-month follow-up. These scores suggest that while psychoeducation was not a primary focus of the therapy, Mary seemed to ha have gained some additional understanding of mental health concepts during the sessions. Moreover, since Mary's initial score was quite high, she didn't have much room to move on the scale.

Qualitative Data at Follow-Up

A few weeks after the last session, Mary responded to the follow up emails from me with the following message in Mandarin:

> I wanted to express my gratitude for your email and your understanding of the situation. Your considerate help meant a lot to me, and I greatly appreciated it. If there is any opportunity to collaborate with you in the future, please do let me know.

I reminded Mary that I was not allowed to continue to treat her in future sessions, but that I would gladly provide her with a referral. Mary did not reply.

Six months after the last session, I reached out to Mary for a brief follow-up meeting (via zoom) to understand Mary's experience post-therapy treatment. Speaking in both of our first languages, Mandarin, Mary shared that she had continued *group therapy* sessions at the same counseling center, which was an option to her. She reported in Mandarin,

> Going to the group and sharing about my issues helped. At least they (group members) give positive feedback and help build confidence. It's somewhat helpful, I feel.

Mary had not engaged in individual therapy since our last session but indicated she had been wanting to find one.

Mary also expressed that she had spent most of the past months practicing English and had become much more confident in speaking it. She said in Mandarin,

> Looking at myself now this semester, compared to when I first arrived in NYC last August, I'm a completely different person. I'm surprised at how much I've changed. It's something I never thought possible before.

When asked about what brought these changes, Mary responded,

> Previously, I might have been afraid of being mocked for inexperience or poor English. This fear might have come from feeling the need to appear perfect. Now, I accept that my English isn't great, but I'm there to learn. There's no pressure to be perfect anymore.

Reflecting on the past treatment, Mary indicated,

> I think it was mostly good. The only thing is, I feel like speaking English in the early sessions was a bit of a waste of time. If we had spoken Chinese earlier, it would have made things clearer and given us more time to discuss many things I wanted to talk about. That would have been much better.

In sum at follow-up Mary described that the therapy had been very helpful to her in becoming much more confident in and less perfectionistic about her English, with positive implications for connecting with an English-speaking learning environment. That the therapy was a positive learning experience is reflected in the fact that Mary was motivated to seek additional therapy in the context of what we both recognized was the counseling center's artificial limitation on the length of Mary's therapy.

Discussion

The course of therapy toward deeper work would not have been possible if Mary had persisted in speaking only English. It took patience, empathy, the fostering of an alliance, and some well-timed and tactful challenges to get Mary to a point where she could use Mandarin. Interestingly, Mary did not mix or switch languages; she transitioned directly from using her second language (L2) to her first language (L1). In bilingual therapy, second language acquisition can be strategically used by clients to avoid discussing certain topics and the depth of areas that represent trauma, conflict, and pain. This phenomenon also occurs in monolingual therapy, where clients may avoid talking about certain topics because they are too painful or will talk "around" the issue. In Mary's case, at the beginning of therapy, she used English (L2) to keep things at a safe and manageable level. She strategically avoided Mandarin (L1) to manage interactions with the therapist and avoid delving into heavier topics. When Mary was finally ready to explore deeper material, she began speaking in her native language, revealing areas of trauma and shame related to her mother, teachers, and authority figures.

Mary was aided by her therapist's fluency in her native language and her therapist's knowledge of some of the cultural traditions in China. As she began to gain confidence in therapy and greater comfort in expressing herself to the therapist in Mandarin, Mary accessed some key memories and poignant moments in her development. The therapy relationship was clearly important; Mary came to see the therapist as caring, trustworthy, and working on her behalf. It is unclear which occurred first: whether the therapist and Mary built a strong enough alliance to help Mary realize it was safe to speak in her native language, or if the change in language and the nature of the therapeutic work made the alliance stronger. It is likely more

complicated than a single cause-and-effect relationship, but the fact that Mary started using L1 indicates that there was a formation of trust and comfort in treatment.

The therapist's feelings toward the ending were undoubtedly influenced by some countertransference. Viewing Mary as someone she was reluctant to let go of reflected a deep-seated concern for Mary's well-being and curiosity about her continued therapeutic journey. The therapist had an underlying fear that without the continuation of the current work, the progress they had made might not be sustained, and Mary might not find the same level of understanding and respect in future therapeutic relationships. From the perspective of transference, the therapy sessions offered Mary a contrasting experience to the authority figures of her past. Instead of reinforcing her previous experiences of harsh discipline and judgment, these sessions allowed her to experience help from others with understanding, respect, and empathy.

Mary's reflection that early sessions in English felt a bit like "a waste of time" nonetheless struck the therapist as "needed and helpful time," during which Mary gained confidence in therapy. The primary task for the therapist during these early sessions involved providing Mary with practical help and support while building a strong connection and a working alliance. It was important for the therapist to honor Mary's request to use English while slowly building a strategy for her to start language mixing or language switching. The therapist's and supervisor's decision to balance Mary's preferences with the therapeutic goals was crucial in facilitating Mary's progress. Interestingly, the fact that Mary felt much more confident in her ability to speak English at the six-month follow-up, which was initially her goal, provided some evidence that both Mary's and the therapist's agendas were addressed in the treatment.

However, there were complicating factors and limitations to the treatment. Mary's lack of previous therapy experience likely shaped her initial expectations and motivations for seeking therapy. She perceived therapy primarily as an opportunity to practice English, which might explain her insistence on using L2 during the early stages of treatment. This expectation added complexity to the therapeutic process, as the desire to speak only English, despite her limitations in using the language, slowed therapy progress and limited focus and depth. The client struggled to put sentences together and often smiled sheepishly as she tried to express the same thought several times, while the therapist struggled to understand and stay focused on what the client was trying to convey. However, as discussed above, this dynamic was identified early on as a relevant psychological issue that required the therapist to remain patient and empathetic.

Missed sessions in a short-term treatment framework, though attributed to various reasons, also represented a complicating factor. These absences likely served as an avoidance strategy for confronting challenging issues, thereby limiting Mary's engagement with the therapeutic process. The inherent limitations of short-term therapy, particularly within a university counseling context, brought unique challenges. While these constraints necessitated a

focus on immediate concerns and coping strategies, they also curtailed the depth and duration of therapeutic exploration. The abrupt ending of the sessions, without a formal closure, underscored the bittersweet reality of such engagements: they can serve as a valuable beginning to a client's journey of self-discovery and healing, yet they leave both client and therapist with a sense of incompleteness.

Language can be used consciously or unconsciously by the client as a protective buffer, mitigating the intensity of emotional and traumatic experiences. This was evident in how Mary navigated her emotional landscape and memories. The case suggests that clients can use their second language (L2), or language in general, to create psychological distance from traumatic events. Conversely, language can also serve as a bridge to emotional and traumatic experiences. Over time, Mary's transition from L2 to L1 allowed her to access more accurate recollections of past events and deeper psychological insights. This interplay of language-switching and mixing in bilingual therapy highlights its importance in emotional processing and psychological growth.

As with many issues and decision points in therapy, it was the therapist's continued empathy, patience, and reflection between sessions, along with supervision, that helped her maintain a stance conducive to furthering Mary's work. Developing a working relationship and human connection with Mary proved essential, enabling the therapist to leverage their discussions toward more challenging work. The therapist's fluency in L1 and knowledge of the cultural milieu where Mary grew up, referred to as "cultural empathy," played a significant role in this process. Cultural empathy allowed the therapist to understand Mary's challenges as she saw them, based on shared language and customs.

While it may not always be practical for therapists to speak the L1 of their clients, particularly given the diversity of the U.S., it is important for therapists to recognize that clients may use L2 to regulate the pace and intensity of therapy and to maintain boundaries. Monolingual therapists can still encourage deeper emotional processing by asking clients to reflect in their native language and then translate their thoughts into English. Exercises such as empty-chair scenarios, where clients address significant others in their L1 and then translate their dialogue into L2, can open pathways to sensitive material and deeper psychological experiences. These exercises require a strong therapeutic alliance where trust and honesty are well established, a prerequisite even for bilingual therapists.

Recommendations

In reflecting on the case, two recommendations emerge. First, it is essential to acknowledge the role of language in bilingual therapy, recognizing that language choice significantly impacts the therapeutic process. The use of L2, instead of L1 when the therapist is fluent in L1, can reflect a strategy to avoid delving into painful material. Clinicians are encouraged to allow clients to use L2 until they are ready to mix, switch, or transition to L1.

Cultural empathy and patience can strengthen the working alliance and prepare the client for the more difficult work of using L1 to discuss deeper issues. Patience and empathy, particularly with clients from different cultural backgrounds, are vital. Therapists must respect the client's autonomy and preferences while encouraging and challenging them to use their native language when appropriate.

Second, it is important to understand that bilingual therapy is not simply "therapy in another language." It is a specialty in the field of mental health, requiring fluency in the client's L1, cultural knowledge, therapist cultural self-awareness, and sensitivity to the client's needs. These needs can include experiences of poverty, bias, oppression, or being undocumented. Bilingual therapy requires specialized training, clinical experience, and supervision to be effective.

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Table 1. Quantitative Data About Mary

Scale (range)	Direction	Range	Clinical Cut-Off	Change That is Statistically Significant	Before first session (range of scale)	After last session	6-month follow up
The Depression Anxiety Stress Scales-21 (DASS-21)	Higher= more distressed						
** Depression		0-42	9	6.19	4	6	10
** Anxiety		0-42	7	6.96	2	2	4
** Stress		0-42	14	6.23	2	0	6
** Total		0-126	28	7.00	8	8	20
Distress Rating (question asked of client)		0-10	--	--	2	7	3
Main Issue (question asked of the client)		--	--		"Overall mental health"	"Easily feel embarrassed"	"Do things I want to do
The Athens Insomnia Scale (AIS)	Higher= more insomnia	0-24	6	--	6	0	4
The Asian American Multidimensional Acculturation Scale-Culture of Origin Scale (AAMAS-CO)	Higher=more acculturation	15-90	--	--	66	56	64
The Attitudes Toward Seeking Professional Psychological Help Scale (ATSPPH)	Higher=more positive attitudes	0-87	20	--	21	26	36
The Mental Health Knowledge Schedule (MAKS)	Higher=more knowledge	12-60	35	--	48	50	50

Table 2. Critical Incident Technique (CTI) analysis of Mary's Therapy Sessions

Session	Critical Incidents (CI)	Processing the Critical Incidents (PCI)	Corrective Responses (CR)
Session 1	Mary's request for using only English despite her limited ability.	Mary wanted to gain confidence in her speaking ability and believed English would allow her to express herself emotionally more easily.	Support her desire to speak only English to help establish trust and the working alliance.
Session 2	NO CI's noted		
Session 3	Mary's palpable fear of judgment and humiliation in everyday conversation.	There seems to be more to Mary than just normative apprehension to speaking English.	Monitor other experiences of perceived humiliation, shame, introduce words or sentences in Mandarin (promote language switching or mixing).
Session 4	Fear of embarrassment if she spoke out in class; passing reference to unpleasant childhood school experiences.	Mary's insistence on speaking English began to appear as a defense, possibly avoiding discussing insecurities, prior humiliation, or unresolved traumas.	Allow her to continue to speak English while continuing to foster trust and a working alliance. Continue to attempt to introduce words or sentences in Mandarin.
Session 5	Breakdown in Mary's communication in English, struggling to find words and express herself.	Mary's exclusive use of English seemed more and more as a defense, limiting psychological experience and engagement, challenging the therapist.	Explore ways to nudge Mary to speak Mandarin, even briefly. Introduce words or sentences in Mandarin.

Session 6	Client resistance to speaking Mandarin when suggested by the therapist.	Client resistance against using Mandarin appeared to limit therapy, maintaining a safe distance from the therapist.	Process resistance with the client, gently explore her apprehension to use Mandarin.
Between Sessions 6 & 7	Client canceled/no showed to two scheduled weekly sessions.	Interpreted as Mary's continued resistance to the interventions encouraging her to speak Mandarin, generating fear, confusion, anger, or resentment.	Called and emailed the client after each missed appointment, gently inviting her to make the next scheduled appointment to discuss. Communicated care and concern.
Session 7	Client started speaking Mandarin early in the session.	The client's resistance had diminished, and the alliance and trust appeared strong enough to facilitate the use of the native language.	Immediately accommodate the client's use of mostly Mandarin and continue to process the emerging material.
	Client discussed harsh discipline and conditions from her mother.	Client experienced everyday hurtful criticisms from her mother, feeling insecure, ashamed, and inadequate. Speaking Mandarin allowed for the discussion of this difficult topic.	Maintain a warm, accepting, and inviting stance to support the client in discussing painful material.
Session 8	Client began the session speaking only Mandarin.	Client seemed to embrace the value of speaking Mandarin and discussing painful past events including shame and hurt.	Respond in Mandarin, listen empathically, and supportively probe for deeper material.

	Client linked hurtful experiences from her mother with current difficulties in confidence and speaking up.	Shift in the therapist's conceptualization of treatment from examining language use as fear of embarrassment to deeper insecurities and traumas.	Listen with empathy, continue to probe and process feelings of shame, hurt, anger, and a sense of inadequacy.
Session 9	Client discussed painful experiences and harsh discipline in primary schools in China.	Broadened expression of hurt beyond her mother's treatment to her social environment, showing increasing confidence in discussing the painful past.	Listen with care and interest, supportively lead client to see links between earlier experiences and current issues with self-concept and social fears.
	Client began discussing her mother in more critical terms and with resentment.	Increasing awareness and insight into how childhood experiences negatively affected her, expressing more self-empathy and self-reflection.	Continue to probe and facilitate deeper exploration and expression of her emotions, fostering corrective emotional experiences.
Session 10	Client recounted an incident involving a boy she liked.	This memory highlighted Mary's shame, inadequacy, painful self-awareness, and negative self-esteem but she accessed and shared it with the therapist.	Process this painful incident, provide empathy, and offer an explanation/interpretation of her reaction and its possible relation to current difficulties.

APPENDIX 1. OUTLINE OF THE CASE STUDY OF "MARY"