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

Reflections on Bilingual Therapy, Defense, and Emotional Access in the Case of "Mary"

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ABSTRACT

Fuertes and Xu (2026) present a case study examining the psychological roles of language in bilingual psychotherapy through their work with "Mary," a Chinese international graduate student navigating anxiety, shame, and acculturative strain. In this commentary, I focus on two main areas: (1) clinical decision-making and mechanisms of change through treatment, and (2) the broader theoretical, training, and service delivery implications that arise from the work. In both areas, language is emphasized as a tool for affective regulation and psychological defense. I also highlight the timing of linguistic challenges in building the therapeutic relationship and the role of the supervisor in providing a supportive and reflective holding environment, and examine the complexities in interpreting outcome data, particularly when changes in symptoms do not clearly match signs of psychological growth. Institutional factors, such as the limitations of short-term university counseling and the need for supervision that responds to cultural and language differences, are also discussed. Overall, the case serves as an insightful way to understand bilingual psychotherapy not merely as treatment across two languages, but as a process that takes place through multiple emotional, relational, and language domains.

Key words: Bilingual psychotherapy; language; affect regulation; psychodynamic psychotherapy; multicultural supervision; international students; cultural psychiatry; clinical case study; case study

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INTRODUCTION

Fuertes and Xu (2026) present a case study examining language as an active psychological process in bilingual psychotherapy. Through their work with Mary, a Chinese international graduate student dealing with anxiety, shame, and acculturative stress, they

illustrate how language can serve both protective and developmental roles throughout treatment. Integrating psychotherapy outcomes research, affective neuroscience, and psycholinguistics, this commentary offers an evidence-based framework for both training recommendations and clinical interpretation.

In line with the approach of *Pragmatic Case Studies in Psychotherapy*, this commentary engages the case in a conversational manner. I will focus on three questions raised by the authors' work:

- How should we understand Mary's use of English as a psychological defense?
- What clinical decisions enabled language to become a mechanism of change (rather than avoidance)?
- What does this case teach us about outcome evaluation and service delivery in bilingual therapy?

Along with these guiding questions, this case prompts reflection on the significance of language itself in the psychodynamic process. In psychotherapy, language is often viewed as a way to convey content rather than as content in its own right. However, in bilingual therapy, the language choice may indicate changes in defense strategies, attachment closeness, and emotional tolerance. Mary's oscillation between English and Mandarin reveals how language can influence psychological safety.

This case highlights the importance to consider not only what is said in treatment, but also how language itself functions as intervention, defense, and vehicle for change.

LANGUAGE AS DEFENSIVE DISTANCE AND THE "LANGUAGE OF PERFORMANCE"

The authors effectively describe Mary's use of English (L2) as emotionally protective. Although she was more expressive in Mandarin (L1), for the first several sessions she insisted on conducting therapy in English, even when this preference limited her emotional articulation. I agree with the authors that this choice was psychologically driven and meaningful rather than pragmatic.

Research on bilingual emotional processing shows that using a second language often reduces emotional intensity and physiological arousal (Dewaele, 2010; Pavlenko, 2005; Dylman & Bjärtå, 2019). From a psychodynamic viewpoint, this aligns with how language can manage emotional closeness and serve as a way to create distance (Freud, 1915/1957; Perry, 1993). In this context, it acts like intellectualization, i.e., the narrative moves forward, but the emotions are modulated.

What stands out in this situation is that English did not just dull her feelings; it also facilitated her engagement. If Mary had been forced to use Mandarin from the start, therapy

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might have crumbled under the weight of early emotional exposure. Here, I share the authors' underlying view that defenses are not barriers to therapy but necessary steps in the process.

We also need to think about the different layers in Mary's use of English. As an international student, English likely served as a "Language of Performance." Speaking in English might have helped Mary adopt a more confident, action-oriented, and future-focused identity, freeing her from the shame connected to her early relationships. English provided both protection and aspiration, shielding her from regressive emotions while connecting her to an idealized self-image associated with academic success and her current self. This created a transitional linguistic space, which was psychologically between the vulnerable child captured in Mandarin and the thriving, motivated adult articulated in English. Recognizing this layered meaning helps us understand why relinquishing English involved not only coping with and tolerating emotions but also reorganizing her identity.

ALLIANCE BEFORE DEPTH: THERAPIST BILINGUALITY AND COUNTERTRANSFERENCE

The therapist's respect for Mary's choice of English in the early stages of treatment was a crucial aspect of their work. By supporting her preference, the therapist prioritized safety and connection over the immediate need to interpret. This not only strengthened the therapeutic bond but also gave the patient the agency and ownership of the language she used in the sessions. Instead of viewing her insistence on English as resistance, the therapist skillfully recognized it as meaningful information.

The fact the therapist (Y.X.) shared Mary's background as a Chinese international student is also significant. In situations with shared cultural backgrounds, I often wonder how much the therapist's own experiences with immigration and cultural adjustment affect their clinical approach. While these shared experiences likely contribute to a supportive environment, they also bring the potential to influence counteretransference and complicate some emotional responses. For example, the therapist's desire to be a "helpful, professional peer" in an American context may have initially reflected Mary's own performance in English. Later, the shift to Mandarin, suggested by the supervisor, marked a significant change as it reshaped the "performance" to foster shared, genuine vulnerability. Consistent with research that shows that using a second language can provide helpful emotional distance in therapy (Dewaele, 2010), adopting English likely helped Mary lessen emotional and cognitive overload.

This was a very clinically appropriate and sophisticated decision that demonstrated strong sensitivity to the therapeutic alliance, a major predictor of clinical success. According to research, a strong alliance is associated with positive clinical outcomes, often outweighing the influence of specific therapeutic schools or techniques according to meta-analytic evidence

accumulated over several decades. It is also considered a more reliable determinant of patient improvement than the patient's baseline characteristics or initial symptom severity (Martin et al., 2000; Flückiger et al., 2018).

I would extrapolate to say that the clinician's early respect for Mary's language preference and skill in maintaining their bond was probably the primary vehicle for meaningful psychological change here. It was a beautiful and thoughtful example of an evidence-based application of alliance theory, which prioritizes collaboration over immediate interpretation.

Another aspect that really stood out occurred in sessions 5 and 6, when the therapist managed to restrain even as the language barrier started to limit depth. Many clinicians might have, out of frustration, impatience, or a desire to deliver help more "efficiently", simply switched to Mandarin. Instead, this therapist was interested in exploring why English was being used. Mary's eventual disclosure that English made it easier to talk about things she found embarrassing was one of the highlights of the treatment. Remarkably, it came not from pressure or confrontation, but from the therapist's patient, gentle, and genuine curiosity. At that moment, language became analyzable rather than merely instrumental.

This also raises important technical considerations regarding the therapist's neutrality and linguistic authority. If the therapist had insisted on using Mandarin earlier, the intervention might have been experienced as coercive rather than supportive, especially given the power differential in cross-cultural settings. Respecting Mary's language choice may have in itself helped heal some emotional and interpersonal wounds as it balanced previous dynamics in which authority figures imposed or dictated how she expressed herself.

In preserving Mary's agency and authorship over the linguistic aspects of her treatment, the therapist's restraint not only protected the therapeutic alliance but also empowered the patient, likely playing a key role in transforming Mandarin from a language associated with imposed evaluation to one of voluntary emotional expression.

CANCELLATION AS COMMUNICATION

The timing of Mary's cancellations, coinciding with language-focused exploration, has important clinical meaning. Although the authors noted this correlation, they stopped short of fully elaborating on its full significance.

From a psychodynamic viewpoint, these cancellations may be read as internal regulatory withdrawals. Cancelling subsequent sessions may have brought Mary some comfort in temporarily distancing herself at a moment when the course of her therapy started to reach shame-laden material. Her eventual decision to return suggests that the alliance was at sufficient strength to metabolize this possible emotional risk.

I would have welcomed some deeper exploration here, particularly regarding the therapist's countertransference during this rupture. For example, did the cancellations evoke anxiety about "losing" the patient? Did they intensify consultation with the supervisor? These dynamics are usually highly relevant clinically, but remain somewhat implicit in their narrative.

The cancellations should also be understood through a culturally mediated lens of shame management. In many cases, withdrawal serves to preserve relational harmony when exposure feels intolerable. Communication then happens in the distancing itself, rather than in direct confrontation. Mary's cancellations may therefore represent not disengagement but a temporary attempt to regulate relational closeness and other internal states while maintaining a therapeutic alliance.

It would be clinically illuminating to know how the therapist addressed these cancellations upon Mary's return. How were they interpreted? Were they normalized? Linked to language exploration? The therapist's response to these absences may offer guidance on whether the rupture felt like further distancing or actually to greater therapeutic openness.

THE TRANSITION TO MANDARIN: EXPOSURE AND ACCESS

Mary's spontaneous switch into Mandarin in Session 7 was another pivotal moment in the treatment course. It is particularly meaningful that this shift was neither imposed (or even prompted) by the therapist nor introduced gradually through code-switching. It happened suddenly, organically, and deliberately.

As anticipated by attachment and linguistic theory and supporting the authors' argument that early relational experiences are often encoded most deeply in the language in which they were originally lived (Pavlenko, 2005), the return to her native language seems to have brought with it a cascade of negative memories including shame, authoritarian teachers, maternal criticism, and peer humiliation.

From an attachment perspective, L1 often functions as the language of early experiences and dependency (Bowlby, 1969/1982). Language in psychotherapy may function not merely as a vehicle for communication but also as a way to regulate affect, attachment, and early relational experiences. It is as if while English allowed Mary to *describe* herself, Mandarin allowed her to *feel* herself. Speaking it in therapy was probably a form of relational exposure, a pattern that closely mirrors my own clinical observations when working with bilingual or trilingual patients in the languages we share. Patients frequently report that certain memories, emotions, or relational states are more accessible (or more difficult to tolerate) in one language than another.

This clinical observation is validated by contemporary research on bilingualism and emotion, with a substantial body of psycholinguistic literature suggesting that first languages are

more closely tied to autobiographical memory and emotional processing when compared to later-acquired languages. Words and experiences often evoke stronger physiological and affective responses in someone's native language, whereas second languages may introduce a degree of emotional distance or attenuation. Experimental and neuroimaging studies have shown that emotional stimuli presented in a bilingual individual's first language tend to produce faster and more accurate responses, as well as stronger neural activation, than equivalent stimuli presented in a second language, and that first languages are more deeply linked to early memories and emotional reactivity (Chen et al., 2015; Dylman & Bjärtå, 2019). Taken together, these findings empirically support the authors' clinical observation in Mary's case, where L1 appeared to facilitate access to shame-laden memories and early relational affect. Conversely, recalling distressing events in a second language might have provided decreased emotional intensity, underscoring the extent to which language choice modulates affective experience and emotional regulation (Dylman et al 2019, Chen et al 2015).

The therapist's use of the Critical Incidents Technique (CIT) served as a "rupture-repair" process. When the therapist finally introduced Mandarin or invited Mary to express specific cultural concepts, it worked as a "bottom-up" intervention. This moved the therapy from a cognitive-behavioral surface processing to more psychodynamic depths (Woolsey, 1986). The timing of this shift, only after the English-speaking "competent self" felt fully accepted, appears central.

The therapist's response here was very clinically elegant. Considering how shifts into a patient's primary language are often accompanied by heightened affect or attempts to access emotionally charged memories, the therapist's attuned responsiveness to language preference becomes particularly important (Verkerk et al., 2021). By following Mary into Mandarin without immediately interpreting or assigning meaning to the shift (e.g., linking it too quickly to trauma), the therapist allowed the emotional material to unfold within a controlled, tolerable space. This approach aligns with the concept of containment, as outlined in Learning from Experience (Wilfred Bion, 1962), where the analyst metabolizes emotional experience before translating it into interpretation, and also with more recent psychotherapy literature emphasizing the value of restraint and linguistic attunement when multilingual patients shift languages during session.

Multilingual psychotherapy research suggests that language choice not only shapes emotional access, rapport, and the overall unfolding of the therapeutic process, but it can also function as a regulatory tool, helping patients manage emotional closeness, identity, and cultural meaning within the therapeutic relationship (Zipper-Weber, 2025).

I see the therapist's decision to simply accompany Mary into Mandarin as a very technically skilled intervention. By choosing presence over explanation, the therapist allowed the

emotional meaning of the language shift to emerge naturally within the therapeutic relationship, ultimately offering deeper emotional access and relational safety.

This transition also invites reflection on the sensory and other embodied qualities that come from language. Patients often report that speaking their first language in therapy changes not just what they say but how they feel and how it is said (vocal tone, posture, and emotional connection). In that sense, speaking Mandarin may have brought back embodied memories, like experiences of being seen, understood, judged, or disciplined, rather than simply bringing back factual recollections.

Switching to Mary's first language was more than just a simple semantic translation; it seemed to spark an emotional response tied to that state. It allowed the therapeutic process to move beyond reflective discussion into something more immediately present and alive. As mentioned before, what stands out here is the therapist's ability to stay with that intensity without rushing to explain, interpret, reassure, or redirect it, which appears to have been central to the treatment's transformative potential.

SUPERVISION AS CLINICAL SCAFFOLD

The authors' supervision inclusion was another notable strength, as it served an important holding environment, particularly around questions of timing language challenge.

I did find myself left curious about moments when supervisor and therapist' perspectives may have diverged (for instance, did the supervisor ever advocate for earlier Mandarin engagement? What reactions did this process elicit in the therapist/ supervisor?)

As discussed earlier, bilingual therapy often intensifies identification processes, and shared migration histories, accents, and cultural scripts may blur analytic distance. Supervisory space often helps metabolize these identifications and restore reflective function. In my own supervision of bilingual and trilingual trainees, I regularly emphasize that language represents only one dimension of the broader cultural matrix, so it is crucial to pay careful attention to the countertransference responses that linguistic but also other cultural aspects may evoke, and how these reactions shape clinical stance, timing, and intervention. Expanding on this supervisory debate would have further enriched the case.

At our community-academic center, which serves a very large immigrant population in New England, this is reinforced through an institutional resource designed to support culturally and linguistically responsive care. Clinicians are encouraged to think beyond language fluency alone and to examine how shared cultural identities and experiences with immigration, acculturation, and linguistic affiliations may shape countertransference reactions and clinical decision-making.

Here it is important to highlight that supervision in bilingual therapy must also consider the supervisor's own linguistic and cultural positioning. Whether linguistically concordant or not, supervisors often participate in a similar web of identification, distance, and projection. Having an open discussion of these dynamics may prevent, or at least mitigate, some of the supervisor's regulations that mirror the very linguistic hierarchies under examination in treatment.

OUTCOME COMPLEXITY: SYMPTOM VS. STRUCTURE

The authors provide a strong analysis of the outcomes. While symptom metrics stayed stable or showed a slight decline during the follow-up period, there were clear qualitative improvements, including better self-awareness, less perfectionism, and a stronger sense of personal agency. Evaluating outcomes in bilingual therapy often raises questions about measurement, as symptom scales used in English might not adequately capture emotional shifts that only come to light in the patient's first language.

Standard checklists often overlook the deep internal changes that occur in psychodynamic therapy (Leichsenring & Klein, 2014), especially when we consider that increased distress can at times actually be a sign of emotional growth instead of regression or deterioration (Fonagy et al., 2002).

Research in psychodynamic outcome measurement suggests that symptom scales may miss important structural changes (Leichsenring & Klein, 2014; Fonagy et al., 2002). In bilingual therapy, measurement can be even more challenging due to language differences. This highlights the need for flexible, multi-method assessments. It's possible that Mary's reporting of symptoms changed not due to increased distress, but because her emotional understanding grew as Mandarin issues became clearer.

Mary's changing expression of her "main issue", moving from vague distress to shame and then to self-direction, represents significant psychological change. The authors' interpretation was quite accurate and convincing as therapy moved Mary from diffuse anxiety to more defined experiences.

Mary's view that the earlier English sessions were "a waste of time" is also clinically meaningful. From her perspective, English felt limiting, while Mandarin seemed healing. Both perceptions hold some truth at different angles and stages.

Therefore, an important, broader methodological issue is raised here: that bilingual therapy outcomes research may need flexible assessment methods that can track changes across emotional states instead of sticking to a single language framework.

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THE CONSTRAINTS OF BRIEF THERAPY

The sudden ending of therapy required by the structure of the counseling center was unfortunate in that it happened just as Mary began to access and confront some deep materials. Rather than completing a journey, the treatment served as a starting point for development. And, even though her symptoms improved, Mary's psychological changes were still very much ongoing at the time of termination.

This gap between short-term service models and a desired deeper growth exemplifies important policy challenges that unfortunately often arise in similar situations. These endings, common in university settings, raise equity concerns for international students, who face significant linguistic, psychological, social, and cultural challenges, along with obstacles like visa issues and academic stress. These students need culturally sensitive and linguistically adaptable support, which may require more time than what many standard university models currently provide.

To ensure safety and effectiveness across cultural and language barriers, policy-makers would ideally recognize that bilingual therapy often requires a slower start and culturally and linguistically appropriate referral pathways.

TRAINING IMPLICATIONS

This case shows that bilingual therapy involves much more than just providing therapy in two languages. It offers a strong reminder that, in these situations, language acts as:

- A regulator of emotional closeness
- A carrier of autobiographical stories
- A marker of interpersonal safety
- A defense against negative exposure
- A bridge to identity integration

Evidence shows that effective bilingual therapy requires more than fluency; it demands linguistic sensitivity and attunement, an understanding of code-switching as a way to regulate emotions, and awareness of linguistic countertransference (Sue & Sue, 2016; Verkerk et al., 2021; Zipper-Weber, 2025). Research supports that integrating these competencies into training programs increases the therapist's ability to respond to cultural and linguistic signals, improving the therapeutic alliance and outcomes.

Training programs should view bilingual therapy as an important specialized skill, one that requires frameworks that go beyond fluency. Clinicians are encouraged to look beyond language fluency alone and consider how shared cultural identities and language ties might shape their own reactions and clinical choices, an awareness that is especially important considering

that language in these cases can serve as a defense, a bridge, and a setting for relationship dynamics.

. Trainees should specifically understand language as a defense, a marker of attachment, and a way to regulate emotions. Supervision, on the other hand, should cover code-switching, translation issues, and language-related emotional reactions. Institutional resources, such as cultural consultation teams and language services, are vital in supporting this type of learning.

CONCLUDING REFLECTIONS

Fuertes and Xu provide an insightful look at bilingual psychotherapy that grounds itself in clinical practice while generating new and important theoretical ideas. One of their main points is that language is not inherently a barrier or a bridge; it is fluid and assumes different roles and representations based on the therapeutic alliance, timing, and the therapist's approach.

During the first stages of therapy, English protected Mary from feeling negative emotions, including shame. Later, Mandarin allowed her to more securely access those emotions. The therapist's ability to honor both of these roles changed language's function from a defensive tool to a mechanism of healing.

For bilingual patients, language is rarely neutral. It serves as a space where identity, safety, and memory are processed. This case shows that when therapists pay attention not just to *what* patients say but also to *how* they express it - specifically, in which language - they can improve the psychotherapy's accuracy and potential.

This case illustrates the principles of evidence-based bilingual psychotherapy by prioritizing the therapeutic alliance, recognizing language as a tool for regulation and connection, and timing interventions based on our understanding of emotional and cognitive processes across languages.

In summary, the authors highlight that changes in language during therapy often mirror changes in psychological states. Defenses, alliances, emotional shifts, and relational openness unfold not only through words but also through shifts in language use. By paying attention to these transitions and respecting them, therapists can intervene more effectively and with greater cultural humility.

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