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

A Response to “Reflections on Bilingual Therapy, Defense, and Emotional Access in the Case of ‘Mary’”

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ABSTRACT

This article responds to Dr. Marcela Almeida’s (2026) commentary regarding our case study of the bilingual psychodynamic treatment of "Mary," a Chinese international student (Fuertes & Xu 2026). This response addresses key clinical and systemic themes, beginning with an elaboration on context-dependent and language-dependent memory literature to support the integration of native language (L1) in bilingual therapy. Re-examining the relational dynamics of the therapeutic dyad, this response clarifies that the therapist's approach was a deliberate clinical stance rooted in shared demographic empathy and maternal/big-sister countertransference, rather than a defensive peer performance. Furthermore, Mary’s consecutive session cancellations are conceptualized as active, existential communications regarding her readiness to cross linguistic and emotional thresholds, rather than standard therapeutic ruptures. This response also discusses how the subsequent shift from English to Mandarin was facilitated through deliberate, supervised "planted" interventions that tested the elasticity of the client’s defenses to allow an organic affective awakening. Finally, the response highlights the limitations of standard English-normed symptom scales within university counseling center models and echoes the call to formalize bilingual psychotherapy as a distinct, rigorous specialty competency supported by linguistically matched, culturally responsive supervision.

Keywords: bilingual psychotherapy; countertransference; language-dependent memory; defense mechanisms; multicultural supervision; university counseling centers; clinical case study; case study

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INTRODUCTION

We are deeply appreciative for Dr. Almeida’s thoughtful comments on our case study. She raises many important points, which have given us an opportunity to think about our conceptualization and treatment of the case. Before delving into her comments, we would like to reiterate the theoretical and empirical bases behind our conceptualization of the case of “Mary”, and the role of language as a component that aids recall. We believe that recall in bilingual therapy is enhanced when the language used in the recall matches the language in which the experiences originally took place. Beyond recall, in Mary’s clinical case, our hypothesis was that emotional re-experiencing, and the associated catharsis would be possible once access to the original experiences was established. We also believed that Mary’s use of L2 (English) was an unconscious way of resisting access to or re-experiencing painful memories.

Research on context-dependent memory has provided empirical support to the phenomenon of improved recall when the retrieval environment matches the encoding, or original environment (Smith, 1988). Substantial experimental work has shown that recall improves when learning and testing occur in the same physical context; reviews and meta-analytic work of this literature has confirmed that the effect is modest but reliable (Smith & Vela, 2001). More recent work suggests that language can function as cognitive context as well, particularly in bilinguals, for whom recall is improved when the language of a test matches the language of learning (Fernandez-Duque et al, 2023).

Our hypothesis based on the available literature is that recall of experiences and associated emotions improves when the language used in therapy matches the language in which the experiences took place. Of interest to us as well, based on the research, is the evidence that language switching (for example from L1 to L2 as in Mary’s case), creates recall competition that reduces access to language-linked cues (Fernandez-Duque et al., 2025). And yet, the use of L2 can help clients feel safer and less overwhelmed when discussing past trauma (Cook & Dewaele, 2022), which in Mary’s case was a necessary precursor to delving more deeply into her experiences using L1.

In sum, the research available indicates that language is not just a medium of communication but appears to serve as a retrieval cue and buffer against emotional pain in bilingual memory.

RE-EXAMINING THE IDENTITY, TRANSFERENCE, AND CULTURAL RESPONSIVENESS

In the commentary, Dr. Almeida (2026) offers an insightful "counter-formulation" regarding the early phase of treatment, questioning whether a subtle countertransference dynamic

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occurred due to the shared demographic backgrounds of the therapist (Y.X.) and Mary, as both were Chinese international students. Specifically, she points that the therapist’s own implicit desire to appear as a helpful, professionally competent peer within an American academic institution may have mirrored Mary’s defensive English "performance”.

Dr. Almeida raises an excellent question here, inviting us to look deeply into the subtle relational undercurrents of the dyad. After careful reflection on the clinical process, we think the early phase of treatment was guided by a conscious, deliberate analysis of language dynamics and psychological defenses, while Y.X. managed the pull from the Mary’s transference. After the first session, the therapist arrived at supervision with a distinct, visceral clinical intuition that "something was missing" or being withheld in the therapeutic space. This intuition was born directly out of the therapist's own lived experience as an international student who had personally navigated the complex psychological adventure of immigration and acculturation. It is our best estimate that rather than creating a blind spot, this shared background provided the therapist with an elevated baseline of empathy and perception. It allowed Y.X to recognize a profound structural fragility in Mary and to discern that Mary’s English "performance" was not merely a linguistic preference, but an active, time-buying defense designed to maintain an emotionally safe distance from vulnerabilities.

Because Mary was assigned to a one-on-one therapy format with a therapist who Mary would immediately recognize by her name as a Chinese woman, her immediate, unconscious relational reaction was likely structured around a fear of authority. In this case, going into the first session, Mary would have marshalled and projected onto the therapist the internal working model of her primary maternal authority figure—an older, critical, and punitive Chinese mother. Consequently, Mary feared that the therapist might critically evaluate or judge her for any perceived inadequacy. It was evident to the supervisor at our first meeting of this case, that Mary’s insistence on using English, her “performance,” to use Almeida’s term, was probably a shield deployed against this anticipated maternal aggression.

If Y.X., had unconsciously reacted to Mary’s fear, she might have overcompensated by attempting to project an image of the "benevolent, non-critical mother" or, conversely, by becoming rigid and demanding when Mary resisted shifting to Mandarin. Our discussions in supervision and Y.X.’s empathy allowed her to remain patient and accepting of Mary’s preferred language, while understanding this preference as emanating from fear and a triggered insecurity. Although the exact structural origins of Mary's transference were still being formulated in the opening sessions, the therapist’s and supervisor’s clinical intuition was acute enough to recognize the intense fear underlying the patient’s defenses. The therapist’s subsequent patience, warmth, and deliberate restraint were not a counter transferential peer performance; they constituted a considered clinical stance.

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Furthermore, Dr. Almeida asks whether the therapist's own immigration journey influenced her clinical interventions. The answer is an unequivocal *yes*, but in our view, this influence is one mechanism that can inform culturally sensitive psychotherapy. The therapist’s personal awareness of how acculturation strains the psyche and how language serves as an affective regulator allowed her to contextualize Mary’s presenting difficulties within a broader systemic and cultural framework. We believe that this shared experiential lens rendered the therapist more sensitive, more informed, and capable of catering to the patient’s latent emotional needs.

To say the shared demographic background left the therapist untouched by countertransference would be an omission; rather than a defense born out of professional insecurity, Y.X.’s countertransference was rooted in a profound, resonant identification with Mary’s linguistic vulnerability. Sitting across from Mary, the therapist was vividly reminded of her own early days in the U.S.—specifically, the deep sense of insecurity, hyper-vigilance, and acute embarrassment that accompanied navigating a new culture in a second language. Y.X. recalled the exposure of being misunderstood or having others react with confusion to her accent. In this relational matrix, Y.X. unconsciously perceived Mary as a younger version of herself. This counter-transferential position manifested not as a peer performance, but as an internal maternal/big-sister stance: an implicit desire to protect, nurture, and gently encourage Mary until she felt safe enough to drop her linguistic guard. This countertransference served a clinical function as well. It provided Y.X. with the psychological stamina to endure her own frustration when Mary’s English became difficult to comprehend. Instead of pushing for premature clarity or switching languages disruptively, the therapist utilized this countertransference to extend Mary an unusual amount of time and patience. This self-awareness allowed Y.X. to transform a subjective, regressive echo of her own past into an objective therapeutic container—holding Mary safely until Mary was ready to bridge the linguistic and emotional divide on her own terms.

More importantly, supervision served as the vital reflective holding environment where these complex threads were untangled. The therapist brought to supervision the real relational frustration of working through Mary’s defensive use of English, which at times fractured the narrative flow, obscured her affective depth and made it genuinely difficult to comprehend her core emotional meaning. Rather than framing this frustration as an unmanaged counter-transference blind spot, supervision illuminated it as a realistic, phase-specific clinical challenge—a natural response to a patient who was actively utilizing a second language to keep the therapist at bay. By processing this friction within a dedicated and supportive space, the supervisor and supervisee were able to analyze the defense objectively rather than reacting to it. Supervision provided the containment necessary to ensure that Mary's behavior remained

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understood as transference, while the therapist's responses to it remained evenly hovering and culturally responsive, rather than a counter transferential enactment. We also discussed in supervision the possibility that Mary’s use of L2 would allow her to warm up to therapy, and that with time, she might feel sufficiently trusting of herself and the therapist to begin to use L1 in the sessions.

CANCELLATION AS COMMUNICATION

Dr. Almeida (2026) offers a compelling framework for interpreting Mary’s sudden cancellation of two consecutive sessions following the intense, language-focused exploration in Session 6. She conceptualizes these missed appointments as "regulatory withdrawals" or mechanisms for culturally mediated shame management and asks whether these cancellations caused anxiety for the therapist or intensified the supervisory process.

Almeida’s emphasis on cancellation as an active form of communication is exceptionally well-taken. After reflection, we think this period of absence is not a standard therapeutic rupture requiring a rupture-repair intervention. Instead, both the therapist (Y.X.) and the supervisor (J.F.) recognized this pause as a profound existential and relational threshold for Mary—a moment where she was fundamentally deciding whether she could trust herself and her therapist. Mary was standing at a psychological crossroads: *Do I cross this bridge into vulnerable emotional exposure, or do I remain behind the safety of my linguistic barrier?* This period of withdrawal evokes a psychological "to be or not to be." For Mary, the choice to return or not to return, to continue or not to continue the treatment, was a choice between two different ways of existing. To remain behind the shield of her English "performance" was a form of psychological survival—enduring her isolating pain and shame in silence. To return to therapy and cross the linguistic bridge meant allowing herself to ease her defensive structure so that a more authentic and affectively engaged self could emerge in therapy.

Because we recognized the depth of this internal struggle, Mary’s cancellations did not induce clinical anxiety or destabilize the therapist. Instead, it focused and deepened our supervisory dialogue. Supervisor and therapist were on the same page, sharing a quiet confidence that Mary was actively working through her resistance and deciding to cross the bridge. In alignment with established clinic protocol, the therapist consistently reached out to Mary following each cancellation and no-show, offering a steady, reliable point of contact without imposing pressure. When Mary did return in Session 7, the therapist did not treat her absence as a clinical infraction or an interpersonal breach that needed to be repaired. Instead, the therapist met her with a grounded, non-demanding presence, validating the courage it took for Mary to return. By respecting the autonomy of Mary's withdrawal and welcoming her back without

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judgment, the therapist demonstrated that the therapeutic relationship was strong confirming that the bridge was safe to cross.

THE SHIFT TO MANDARIN: PLANTED INTERVENTIONS AND ORGANIC AWAKENINGS

Dr. Almeida (2026) provides a remarkable description of Mary’s transition from English to Mandarin in the later sessions, conceptualizing it not only as a semantic translation but as a "state-dependent activation." She highlights how this linguistic pivot altered Mary’s somatic presentation—transforming her vocal tone and unlocking affective memories. We agree with Almeida’s observation of this somatic and experiential shift; the transition indeed carried an intensely grounded, physical, and organic quality. It is also important to clarify that this shift was also the result of carefully cultivated, "planted" clinical interventions.

While the eventual emotional breakthrough felt organic, the psychological soil had been deliberately prepared in supervision. As noted previously, the therapist (Y.X.) and supervisor (J.F.) spent significant clinical energy analyzing Mary’s rigid adherence to English as a defensive barrier. Recognizing that deep therapeutic work might remain stalled as long as Mary operated in her second language (L2), the supervisor explicitly encouraged the therapist to introduce Mandarin words and phrases strategically "here and there" into the dialogue. This was not a forceful demand for Mary to switch languages, but rather a subtle, micro-interventional technique designed to "test" Mary's affective response and her psychological readiness for deeper exploration.

By planting these linguistic seeds, the therapist actively tested the elasticity of Mary’s defenses. Each intentional introduction of a Mandarin word served as a gentle invitation, signaling to Mary that her native language—and the intense, primary emotions bound up with it—was safe to bring into the room. When Mary finally accepted this invitation and leaned fully into Mandarin, the transition was indeed organic because it arose from her own internal readiness, but it occurred precisely because the structural scaffolding had been quietly and deliberately laid down. This interaction demonstrates that in bilingual psychodynamic therapy, the activation of state-dependent affective memories is rarely a matter of mere happenstance; rather, it is a beautifully synchronized dance between deliberate, supervised technique and the patient's organic relational awakening.

SYSTEMIC LIMITATIONS

Dr. Almeida (2026) highlights a critical tension between Mary’s stable or slightly worsened symptom scores and her structural psychological growth (e.g., self-reflection). She notes that standard English symptom scales fail to capture deeper shifts occurring in a patient's

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native language. Furthermore, she exposes that the brief university counseling center (UCC) model brought a termination just as Mary accessed her core shame narratives.

Operating within a UCC framework, we followed the standardized assessments. If evaluated strictly through these English-normed symptom scales, this case would appear to have been less than successful. But Almeida raises a rich point, that standard assessment is limited in assessing progress, and may miss advances in treatment, including the structural and linguistic reorganization of the psyche. Mary left therapy still in pain, but feeling stronger and seemingly possessing an expanded emotional vocabulary and enhanced self-compassion. As Dr. Almeida points out, this has implications for how we traditionally assess progress and outcome, particularly in settings where personal growth, recall and processing of memories, and resolution of trauma take place.

MULTICULTURAL SUPERVISION AND TRAINING

Finally, Almeida (2026) addresses an issue by emphasizing that bilingual psychotherapy must be formalized as a "subspecialty competency." We agree that language fluency should never be conflated with clinical competence. Furthermore, she invites us to consider the dynamics of multicultural supervision, specifically raising the question of how clinical progress is impacted when a supervisor and a therapist hold diverging conceptual models or disagree on the trajectory of treatment.

We enthusiastically echo Almeida’s primary assertion regarding training. Conducting depth-oriented psychotherapy across two languages requires a sophisticated set of clinical micro skills, an understanding of the tracking of defensive language-switching, and culturally responsive training. It is an entirely distinct modality that cannot be left to an assumption of native linguistic fluency. Fuertes (2004) noted that conversational linguistic proficiency does not equate in any way bilingual clinical competence. Qualitative research tracking the experiences of bilingual trainees indicates that providing services in a non-English language often occurs with minimal formal training or institutional support, requiring trainees to navigate the added cognitive and practical effort of translating session materials for monolingual supervisors (Johal, 2017; Trepal et al., 2014). When training program fail to offer specialized coursework or linguistically matched supervision, bilingual trainees are often forced to shoulder the exhausting double-duty of serving as both clinician and cultural translator. True clinical fluency requires the practitioner to understand language as a deeply embedded cognitive and emotional context. Without explicit training on how to handle code-switching, linguistic defenses, and the somatic shifts associated with state-dependent bilingual memory, a native-speaking therapist is left under-equipped to manage the complex relational configurations that arise in cross-linguistic care (Acevedo-Weatherholtz et al., 2023).

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To address Almeida's question regarding supervisory disagreement, in this particular case, the supervisor (J.F.) and the therapist (Y.X.) did not experience a divergence in their conceptual models. Rather than an outright disagreement, our process was characterized by a difference in viewpoints that ultimately enriched the treatment. The therapist frequently brought her clinical frustration to supervision regarding Mary’s persistent use of English and emotional detachment, at times feeling frustrated with the pace and progress of treatment. While the therapist experienced the weight of this day-to-day impasse in the room, the supervisor quickly read the client’s use of L2 as psychodynamic resistance. Accordingly, the supervisor emphasized patience with the client, validating the therapist’s frustration as a valuable diagnostic indicator rather than an indication that therapy was somehow not progressing adequately. This point highlights the critical importance of competent supervision by a supervisor specifically trained and experienced in bilingual therapy.

This shared curiosity allowed supervision to function as a collaborative clinical incubator. The supervisor advocated for a strategic approach, suggesting that the therapist introduce a Mandarin word or phrase "here and there" to deliberately test Mary's emotional readiness. While such advocacy might superficially appear "pushy" or overly directive in a traditional non-directive framework, within a culturally informed psychodynamic model, it was a calculated intervention. Because supervisor and therapist were unified in their understanding of the patient’s defense, this active stance served to empower the therapist, giving her the tactical tools needed to test the linguistic barrier and safely guide Mary toward her emotional breakthrough.

SERVICE DELIVERY AND IMPLICATION

In her concluding remarks, Almeida (2026) expands her analysis beyond the immediate clinical dyad to address the broader clinical psychology training and mental health service delivery. She rightly urges, from our perspective, that the field look critically at how training institutions and service providers accommodate—or fail to accommodate—the intricate psychological needs of culturally and linguistically diverse populations.

We enthusiastically echo Almeida’s concerns. Within many contemporary training paradigms, there remains an implicit, reductionist assumption that bilingual therapy is simply "therapy conducted in another language." This view overlooks the profound psychodynamic and linguistic complexities inherent to the modality. As Mary’s case demonstrates, working across two languages demands an entirely unique framework of clinical practice. It requires specialized theoretical groundings in bilingual development, identity negotiation, and acculturative trauma. Furthermore, it necessitates the acquisition of specific clinical microskills—such as tracking defensive language-switching, assessing state-dependent affective shifts, and managing

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culturally mediated shame—all of which rely heavily on access to culturally informed, linguistically matched supervision (Santiago-Rivera & Altarriba, 2002).

The field of clinical psychology should treat bilingual therapy as a rigorous, distinct specialty competency. It is our hope that the case of Mary and Dr. Almeida's insights have provided the readers with a persuasive argument for recognizing language not merely as a tool for communication, but a store and conduit of emotional experiences and memories, which can remain dormant or hidden, or might be properly attended to and processed in treatment.

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