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Self-Identifying Latino/a/x Former Mental Health Therapy Clients' Experiences Receiving Mental Health Therapy

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Abstract

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MS, Walden University, 2015

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Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

The Latino/a/x population in the United States continues to increase as does the need for mental health professionals who are bilingual and knowledgeable on multicultural issues. Spanish is the native language spoken in approximately 13% of the households in the United States, with 36% of Spanish-speakers seeking mental health treatment. Research on therapists serving Latino/a/x clients indicated that therapists struggled to provide culturally sensitive and linguistic appropriate interventions. While therapists' challenges and experiences have been explored, little is known on the therapeutic experiences of Latino/a/x former clients. The purpose of this interpretative phenomenological analysis was to explore the therapeutic experiences of self-identifying Latino/a/x former mental health therapy clients, how they perceived cultural components in therapy, and how they evaluated the overall outcome of therapy. The conceptual framework for this study was based on an integrative framework in mental health treatment for Latinos. Data were collected from semi structured interviews with 10 former Latino/a/x clients. Results of thematic analysis indicated that participants found it helpful when therapists allowed for language switching, asked about their culture, and showed a genuine interest in it, shared the same or similar cultural background, and were of the same gender and close in age to the participant. The results of this study have the potential to be used for positive social change in the creation and implementation of culturally appropriate interventions for therapists who provide services to Latino/a/x clients.

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Dedication

I dedicate this study to Latino/a/x people who have sought mental health treatment to become improved versions of themselves. I dedicate this study to my parents who have always supported my education. If it were not for my parents' love, encouragement, and support, I would not have realized my potential for obtaining my doctorate degree. I dedicate this study to my three amazing children. You have been my best accomplishments in life. I hope that seeing your mother persevere through adversity over the years shows you that anything is possible. I dedicate this study to my dog who has been an ever-faithful companion for 11 plus years and waited until I defended my dissertation to pass over the rainbow bridge. Lastly, I dedicate this study to my husband and best friend. I seriously do not know how I could have gotten through this journey without your friendship, support, encouragement, and love. You always listened, provided a shoulder to cry on, motivated me to never give up, brought me hot tea or water while I wrote, and made some really great meals when I just did not have time to cook. You all are my rock!

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First and foremost, I have to thank God for His love for me throughout my life. Many times, when I was feeling overwhelmed, God showed me that He would never give more than I can handle.

I want to thank my parents for their support throughout this journey. You have been my biggest cheerleaders. And while it may have been embarrassing to hear you brag about me becoming a "doctor" to all of your friends (and even strangers), I know you did it because you were so proud of your only child. Hey, look Mom & Dad, I made it!

To my children, I want to thank you for allowing me to be your mom. I love being your mom and I honestly could never tell you enough how proud I am of each of you. I seriously do not know what I did to deserve the three of you, but I consider myself the luckiest mom in the whole world. You'll be in my heart… always!

To my husband, it is hard to believe that we have known each other since we were in middle school, only to reconnect later in life and marry. The past 11 years you have been my best friend. Without your unconditional love, words of encouragement, hugs, and support, there is no way I could have made it through this doctoral journey. I am thankful for you and your daughters being part of our family. You matter to me; I promise you do.

Thank you to my doctoral committee members who provided invaluable insight and tutelage. My chair, Dr. Susana Verdinelli, mil gracias por nunca rendirme. Con sus contribuciones a la comunidad hispana, he podida pasar por este viaje sabienda que mi studio significa tanto para usted como para mí. My committee member, Dr. Reba

Glidewell, I knew when I met you during BAYR classes that I had to work with you. There was no “it depends” for me. Thank you for never giving up on me either and for being my methodologist.

I want to shout out to my BAYR classmates who have become lifelong friends in this doctoral journey. We made it through 500+ hours together in Minnesota and I loved every minute of it! Thank you for your friendships!

Lastly, I want to thank the participants in my study for sharing their lived experiences openly and honestly with me. I enjoyed the conversations with each of you. I hope your participation in this study will give you pride knowing that it will help other Latino/a/x persons who are going through or will go through mental health therapy.

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Chapter 1: Introduction to the Study

Introduction

Bilingual therapists making use of the native language of the client who prefers to speak in their native language should be properly trained to provide the most effective service in order to allow their client the opportunity to be more comfortable during therapy sessions. By eliminating a communication gap, bilingual therapists may provide a deeper alliance with their clients who speak their native language in session. How and where the bilingual therapists received their language training, as well as their ethnic self-identification, may play a significant role in their comfort level and ability to provide Spanish language services. By having a better understanding of the therapeutic experiences of the client who identifies as Latino/a/x and may be bilingual in English and Spanish, this study can bring about positive social change for both the client and training programs for monolingual and bilingual therapists.

In this study, I explored the experiences of self-identifying Latino/a/x former mental health therapy clients who had therapeutic sessions with a monolingual English-speaking or bilingual Spanish-English speaking therapist. Through this study, a better understanding of former clients' perceptions of their therapist as well as their experiences from their sessions of working with a therapist is provided. Chapter 1 reviews the background on bilingual therapy services, the problem and the purpose of the study, the theoretical framework, the methodology that I used to respond to the research questions, definition of terms, and limitations of the study.

Background

The literature found on this topic within the past 10 years has primarily focused on the experiences of the therapist working with bilingual clients in order to provide a broader insight into the needs of the therapist in the bilingual therapeutic setting. Altarriba and Santiago-Rivera's (1994) landmark paper indicated that there is a lack of research on language in the evaluation and treatment processes of Spanish-speaking clients. The authors emphasized the importance of acculturation in therapy in which the therapist can successfully design and implement a treatment plan that considers the client's culture, language, age, gender, and immigration status. From their study, the authors recommended future research to be done on the use of language in the therapeutic treatment plan in which the client's native language is mixed into the therapy. While this study was conducted 25 years ago, Altarriba and Santiago-Rivera (1994) were pioneers in this research and have provided significant contributions to bilingual counseling.

Castaño et al. (2007) and Pro et al. (2022) recognized the large gap in mental health services available to Spanish-speaking clients in their native language. The authors spoke with mental health providers who provided services in Spanish and what their experiences and concerns were regarding their training and level of competence in providing services in Spanish. The authors identified the need to provide better training for those who provide mental health services in Spanish. They also discussed the necessary efforts to educate graduate psychology students providing bilingual services to their future clients and how training must provide a focus on this so that Spanish-speaking clients' needs are being met. When this paper was written, there were no

standards to determine what the minimum requirements would be for mental health professionals to provide services in Spanish and how monolingual supervisors could best supervise their bilingual supervisees when they themselves were not educated in bilingual/multilingual languages.

Verdinelli and Biever (2009a) conducted a qualitative study comprised of 13 phone interviews with therapists who were native Spanish speakers and those who were U.S. born Spanish speakers or heritage speakers. From this study, they found that both types of Spanish speakers felt pride in being able to converse with their clients who speak Spanish. However, they still expressed the need for further training in bilingual counseling. In later research, Verdinelli and Biever (2013) had 14 therapists whose native language was English, did not identify as Latina/o, and were willing to provide therapy in Spanish to Spanish-speaking clients. These therapists spoke Spanish as a second language but did not receive any formal training in providing therapy in Spanish. From the study, Verdinelli and Biever (2013) found that the Spanish-speaking clients' initial doubts about therapy were relieved when their therapist spoke to them in their native language and shared interests in their cultural values.

In reviewing the literature, the clarity of the need to hear from former clients became more apparent because of the saturation of therapists' experiences and viewpoints already being researched. The examples of studies that delved into the therapists' experiences provided the background for the significance of this study and identified the gap in the literature that the clients' experiences should be reviewed and understood to further educate therapists who provide bilingual services.

Problem Statement

In the United States, the Latino/a/x population accounts for more than half of the growth within the past 12 years, with a projection of being the third fastest growing population over the next 40 years (Dali, 2022). However, there are very few therapists who are able to provide services in the client's native language. Many times, the therapists who provide therapy in the client's native language do not have the proper training in the foreign language as it relates to psychotherapy. When the therapist is adept at the client's cultural values, native language, socioeconomic status (SES), and gender, it makes it possible to provide an individualized therapeutic plan (Bernal et al., 2009; Gainsbury, 2017).

With an ever-growing population of Latino/a/x in the United States, the problem of having therapists who are well-versed in multiculturalism, as well as who are able to speak Spanish and English, to provide services will become increasingly pertinent for this population. As of 2015, there were a dozen schools within the United States that offered mental health education conducted in Spanish and that included multicultural training (Ding et al., 2019; Stringer, 2015).

Therapists who provide Spanish speaking services may be challenged in their feelings of competency and confidence when working in Spanish (Verdinelli & Biever, 2009b, 2013). Therapists in various studies reported difficulties expressing themselves in Spanish due to a limited vocabulary of psychological concepts in Spanish (Castaño et al., 2007; Sprowls, 2002; Verdinelli & Biever, 2009a, 2009b, 2013; Pro et al., 2022). Therapists also reported that their lack of language competency often led to a delay in

providing timely responses to their Spanish speaking clients as they grappled with remembering or finding the correct terminology (Castaño et al., 2007; Verdinelli & Biever, 2013; Estrada et al., 2018). The various challenges that Spanish speaking clients face within a therapeutic setting with a therapist who states they are bilingual have yet to be explored.

Purpose of the Study

The purpose of this phenomenological study was to explore the experiences of self-identifying Latino/a/x who received mental health therapy. I aimed to explore how self-identifying Latino/a/x former mental health clients perceived the use of language in therapy, the therapists' skills in language and cultural competence, and their overall assessment of the therapy experience. Finally, I explored self-identifying Latino/a/x former mental health clients' recommendations regarding mental health therapy.

Research Questions

The research questions for this study were as follows:

- Research Question (RQ) 1: What are self-identifying Latino/a/x former clients' experiences in mental health therapy?
- RQ2: How do self-identifying Latino/a/x former clients perceive cultural variables such as language and ethnicity in the therapeutic process?
- RQ3: How do self-identifying Latino/a/x former clients assess their relationship with their therapist and the overall outcome of therapy?

Conceptual Framework

In this study, I used Santiago-Rivera's (1995) integrative framework in mental health treatment for Latinos. Santiago-Rivera (1995) and Collins and Arthur (2010) established a robust case for the inclusion of culture and language in therapeutic services for Spanish-speaking clients. Collins and Arthur (2010) posited that when there is an awareness of the client's cultural background and contextual experiences, the therapeutic alliance develops in a sensitive environment. Santiago-Rivera (1995) stated that assessing clients' level of acculturation, immigration status, language preference and use, as well as customs, values, and norms, is essential for the development of a client-focused treatment plan. This framework has been used across a wide range of theoretical orientations and therapeutic approaches; it provides client context. This conceptual framework may assist in formulating an understanding of how self-identifying Latino/a/x former clients have experienced the therapeutic encounter.

Nature of the Study

In this study, I used an interpretative phenomenological analysis (IPA; see Charlick et al., 2016; Pietkiewicz & Smith, 2014; Roberts, 2013; Smith et al., 2009) to answer the RQs. A qualitative methodology was the most appropriate for the objective of this investigation, as in-depth, self-identifying Latino/a/x former clients' experiences in therapy are intended to be understood through the completion of this project. This study also aligned with a qualitative approach, given that little is currently known within the existing literature about the personal experiences of self-identifying Latino/a/x former mental health therapy clients. IPA was selected for this project given the RQs' implied

interest in personal perspective on lived experiences. IPA refers to the manner in which events, people, and objects occur to a participant within their context. The orientation of phenomenology within IPA targets the identification of the fundamental experiences, or phenomena, which make them unique from others' experiences (Pietkiewicz & Smith, 2014; Taylor, 1985).

Definitions of Terms

Bilingual: Common term referring to a person who speaks two languages.

Former client: Common term referring to a client who is not currently seeking treatment from a professional. In this study, the licensed therapist was the professional, while the former client received treatment within the past 3 years.

Hispanic/Latino/a/x: Common term referring to a person whose heritage is from a Spanish-speaking country.

Native speaker: Common term referring to a person whose language at birth is a specific language; in this study, native Spanish speaker or native English speaker.

Spanish-speaking: Common term referring to a person who speaks the Spanish language.

Assumptions

I assumed that the participants in the study responded to the RQs openly and honestly.

Scope and Delimitations

The results of the study were limited to self-identifying Latino/a/x former mental health therapy clients. Other native foreign-language speakers were not within the scope of this study, which limited the scope of the study to the Latino/a/x community.

Limitations of the Study

- Access to self-identifying Latino/a/x former mental health therapy clients was difficult to ascertain.
- Identifying self-identifying Latino/a/x former mental health therapy clients needed to be found through bilingual or monolingual therapists who were willing to share the study's information with their former clients. Relying on said therapists to provide information on the study to former clients was a barrier to finding participants.
- The willingness of former clients to participate in the study was a challenge because they may not have wanted to share experiences of their relationship in therapy if those experiences were more traumatic than helpful.

Significance

Knowing the experiences of self-identifying Latino/a/x former mental health therapy clients, who sought mental health services, could better serve clients and therapists alike. Through the exploration of former clients' experiences, I addressed how former clients assessed the outcome of their therapeutic process, their satisfaction with the process, and how factors such as therapists' cultural competence and language proficiency contributed to the outcome and satisfaction in therapy. From this study, I

provided a new perspective related to Spanish-speaking therapeutic services based on the experiences of former clients. The results of this study contributed to the bilingual mental health field by providing an account of former clients' perspectives on receiving mental health services.

Summary

Within this Chapter, an overall description of the study's phenomenon was provided, along with the conceptual and empirical foundation for the purpose of the study and the basis for the RQs. Definitions of the key terms used in the study were clearly identified in order to ensure a proper understanding of the terminology. The limitations, delimitations, scope, and assumptions were discussed so that aspects, weaknesses, and boundaries of the study were understood before beginning the study. This rich discussion assisted with bringing positive social change in the therapeutic alliance between self-identifying Latino/a/x clients and their therapist. The next Chapter in the study, Chapter 2, will address the foundation for the basis of the study by exploring current literature related to the nature of this study.

Chapter 2: Literature Review

Introduction

In the United States, the Latino/a/x population accounts for more than half of the growth within the past 12 years, with a projection of being the third fastest growing population over the next 40 years (Dali, 2022). However, there are very few therapists who are able to provide services in the client's native language. When the therapist is adept at the client's cultural values, native language, SES, and gender, it is possible to provide an individualized therapeutic plan (Bernal et al., 2009; Gainsbury, 2017). In order to gain a better understanding of the usefulness of bilingual psychotherapy, the clients' experiences need to be explored (Benuto & Leany, 2017; Elliott & James, 1989; Hodgetts & Wright, 2007; Kokaliari et al., 2013; Lebron-Striker, 2012; Marusiak, 2012; Romero, 2013; Trepal et al., 2014; Verdinelli & Biever, 2013). All that is known regarding bilingual therapy is based on the therapists' views (Carmen Calvo□Rodríguez, 2021; Costa & Dewaele, 2012; Kapasi & Melluish, 2015; Kokaliari et al., 2013; Lebron-Striker, 2012; Nino, 2013; Romero, 2013; Santiago-Rivera et al., 2009; Trepal et al., 2014; Verdinelli & Biever, 2013; Verkerk et al., 2021). The experiences of self-identifying Latino/a/x former clients as it relates to their therapeutic history are unknown.

With an ever-growing population of Spanish speakers in the United States, the problem of having properly trained bilingual therapists available to provide services will become increasingly pertinent for this population. As of 2015, there were only a dozen schools within the United States that offered bilingual mental health training (Ding et al., 2019; Stringer, 2015). The bilingual therapists received little to no specialized training to

provide therapy to bilingual clients (Biever et al., 2011), and instead, they mainly learned this skill by practicing (Verdinelli & Biever, 2013). Bilingual therapists received limited supervision (Verdinelli & Biever, 2009a), and employer verification of bilingual therapists' Spanish proficiency was lacking (Verdinelli & Biever, 2013). Many problems arise when the therapist is not skillful in providing bilingual therapy; the therapists may not have the linguistic complexity needed to describe therapeutic interventions to their clients, conduct therapy in the second language, or provide accurate psychological assessments (Biever et al., 2011; Interiano-Shiverdecker et al., 2021; Lebron-Striker, 2012; Romero, 2013), resulting in clients' leaving treatment prematurely or receiving an inaccurate diagnosis or assessment.

Both cultural competence and language proficiency are key components when providing services to bilingual clients (Castaño et al., 2007; Verdinelli & Biever, 2009a, 2009b; Pro et al., 2022). Competence in providing services to bilingual clients includes acquiring proficiency in the Spanish language, showing knowledge about Latino culture, and demonstrating skills to design appropriate interventions to work with Latino clients (Santiago-Rivera & Altarriba, 2002). Latino therapists described robust connections with their clients who spoke Spanish; however, the authors stated that it was unknown if the clients shared the same feelings about their relationship with the ethnically matched therapist (Delgado-Romero et al., 2018; Ramos-Sánchez, 2009; Santiago-Rivera et al., 2009).

Therapists providing bilingual therapy struggle at various levels. They have reported feeling less confident and competent when working in Spanish (Verdinelli &

Biever, 2009a, 2013) and again have a limited technical vocabulary and difficulty expressing psychological concepts in Spanish (Castaño et al., 2007; Estrada et al., 2018; Sprowls, 2002; Verdinelli & Biever, 2009a, 2009b, 2013). The bilingual therapists have also found difficulty understanding the different idioms, expressions, and in particular, the vocabulary used by different Spanish-speaking groups (Estrada et al., 2018; Verdinelli & Biever, 2013). They reported delaying the therapy process when searching for the right words in Spanish and felt that the lack of language proficiency interrupted the conversational flow (Castaño et al., 2007; Estrada et al., 2018; Verdinelli & Biever, 2013; Pro et al., 2022). As of today, there has not been any study exploring former clients' perceptions and reactions to issues presented in the Spanish-speaking services they received therapy. The various phenomena that were occurring in bilingual therapy, including the use of language in therapy, the therapists' challenges providing bilingual therapy, and therapists' cultural competency, have not been explored from self-identifying Latino/a/x former clients' perceptions.

The purpose of this phenomenological study was to explore the experiences of self-identifying Latino/a/x former clients who received mental health services. I also aimed to explore how former clients perceived the use of language in therapy, the therapists' skills in language and cultural competence, and their overall assessment of the therapy experience. Finally, I explored former clients' recommendations regarding mental health therapy.

The literature review that follows provides a justification and explanation of the theoretical framework used in this study. A review of the literature begins with a

justification of the methods used to explore what has already been written, then delves into the history and statistics of bilingual therapy, and culminates with a thorough summation of the current literature as it relates to the variables of the bilingual therapist, and what little is known, yet is crucial to be known, regarding the clients' experiences with Spanish-speaking services.

Literature Search Strategy

Literature was retrieved using Walden University's Psychology databases. Google Scholar was also used to search for peer-reviewed, empirically-based articles. From the Psychology database, *PsycINFO, PsycARTICLES*, *ProQuest Central,* and *ProQuest Dissertations and Theses* were searched. Statistical information regarding the Spanish-speaking population in the United States and the number of Spanish-speaking individuals potentially needing therapy via published government reports was researched. There were very few exact articles related to *clients' experiences* and *Spanish speaking* and *therapy*. Within the search fields, the terms used included *client(s), experiences, culture(al), therapy, bilingual, Spanish speaking, multicultural, competence, language, cultural diversity, qualitative, IPA (interpretative phenomenological analysis), language switching, bilingualism, multilingualism, acculturation, ethnicity, alliance, race,* and *perceptions.*

Conceptual Framework

In this study, I used Santiago-Rivera's (1995) integrative framework in mental health treatment for Latinos. Santiago-Rivera (1995) and Collins and Arthur (2010) established a robust case for the inclusion of culture and language in therapeutic services

for Spanish-speaking clients. Collins and Arthur (2010) posited that when there is an awareness of the client's cultural background and contextual experiences, the therapeutic alliance develops in a sensitive environment. Santiago-Rivera (1995) stated that assessing clients' level of acculturation, immigration status, language preference, and use, as well as customs, values, and norms, are essential for the development of a client-focused treatment plan. This framework has been used across a wide range of theoretical orientations and therapeutic approaches; it provides client context. In this study, the integrative conceptual framework assisted in formulating an understanding of how self-identifying Latino/a/x former clients experienced the therapeutic encounter.

The conceptual framework for this study involved four concepts from Santiago-Rivera (1995) related to the therapeutic treatment for Spanish-speaking clients and how those concepts relate to their experience in treatment (see Table 1). The framework also includes the three concepts of cultural background and contextual influences related to the alliance in a multiculturally aligned therapy as researched by Collins and Arthur (2010). The following matrix outlines and defines the concepts from Santiago-Rivera (1995) and Collins and Arthur (2010) and how the framework illustrated the intent of the study.

Table 1

Conceptual Framework Concepts

Concepts	Level of acculturation	Immigration status	Language preference and use	Customs/Values/Norms
Former clients' perceptions	The former clients' perceptions regarding the level of their own acculturation The former clients' perceptions of the therapist's level of acculturation	Their immigration status affected their perception of the therapeutic alliance	The lack of language use negatively affected the former clients' perceptions Use of language and preference of native language or second language positively affected the former clients' perceptions.	The perceptions of the therapeutic experience of former clients was enhanced by the customs/values/cultural norms of the client and therapist The perceptions of the therapeutic experience of former clients was inhibited by the customs/values/norms of the client and therapist
Relationship with therapist	Relationship with the therapist is enhanced by the therapist's level of acculturation. Relationship with the therapist is hindered by the therapist's level of acculturation	The relationship with the therapist was affected by the immigration status of the former client.	Language preference and usage positively affected the relationship with the therapist Language preference and use negatively affected the relationship with the therapist	The customs/values/norms of the therapist or the client contributed to the relationship of the former client with the therapist.

Concepts	Level of acculturation	Immigration status	Language preference and use	Customs/Values/Norms
Overall outcome of therapy	The level of acculturation of the therapist affected the overall outcome of therapy	The outcome of therapy for the former client was limited due to their immigration status of the former client	The overall outcome of therapy was positively influenced by the use of preferred language by the former client and therapist. The overall outcome of therapy was negatively influenced by the use of preferred language by the former client and therapist	Customs/values/norms of the client or the therapist contributed positively to the overall outcome of therapy for the former client Customs/values/norms of the client or the therapist contributed negatively to the overall outcome of therapy for the former client
Culturally sensitive working relationship	When infused with a multiculturally competent alliance between the therapist and client, a culturally sensitive working relationship can be formed			
Cultural background	Inclusion of country of origin, race, ethnicity, religion, age, sexual orientation, gender, language, socioeconomic status, and ability			
Contextual influences	Inclusion of historical and environmental circumstances			

The concept of cultural background, as defined by Collins and Arthur (2010), is inclusive of not only the country of origin but also their race, ethnicity, religion, age, sexual orientation, gender, language, SES, and ability. By having a clear understanding of the client's cultural background, as opposed to a generalized assumption of one culture's background, the therapeutic plan can be personalized and meet the needs of the individual client.

Collins and Arthur (2010) provided both an overview of the history of multicultural counseling and a critical analysis of current multicultural counseling competence and frameworks. They reviewed a new culture-infused counseling method that focused on the working partnership between counselors and clients (Collins & Arthur, 2010). With a push for introducing a working alliance concept and multicultural counseling competence, there could be a better understanding of the culture-specific inferences that could affect the counselor-client relationship. Santiago-Rivera (1995) explored the role of culture and language in relation to mental counseling treatment for Spanish-speaking clients. A conceptual framework that allowed for reflection of the Spanish-speaking client’s language and culture into the therapeutic process was examined as a viable integration into their treatment. Santiago-Rivera (1995) suggested that counselors-in-training consider the framework as a guide on how to integrate linguistics and culture into their intervention strategies, which could assist in the design of the Spanish-speaking client’s treatment plan.

Prior Application of Conceptual Framework

When there is a better understanding of how being culturally aware and sensitive, and being multiculturally competent within the confines of a therapeutic alliance, the therapist is able to provide a more holistic and inviting experience for the Spanish-speaking client (Arthur & Collins, 2011; Banka, 2017; Biever et al., 2011; Collins & Arthur, 2010; Collins et al., 2010; Diskin, 2013; Gallardo, 2013; Green et al., 2018; Hall et al., 2014; Hipolito-Delgado & Reinders-Saeman, 2017; Hook et al., 2016; Interiano-Shiverdecker et al., 2021; Lebron-Striker, 2012; Niño et al., 2016; Ramos-Sanchez, 2009; Santiago-Rivera, 1995; Santiago-Rivera & Altaribba, 2002; Schouler-Ocak, 2020). The various studies have concluded that the use of an integrative framework when the therapist provides an environment that includes the language preference of the client, culture awareness, multicultural competence, and cultural sensitivity allows for a better working relationship between client and therapist.

Literature Review Related to Key Concepts

Within the focus of this study, there are several topics that correlated with the variables of a bilingual therapist as defined by Santiago-Rivera (1995) and Collins and Arthur (2010). The terms described in the literature review correspond with the concepts of various studies, which provide a broad background of the characteristics of therapists who provide therapy to Spanish-speaking clients.

Cultural Competence

When the therapist is culturally adapted to the client's cultural values, native language, SES, and gender, it makes it possible to provide an individualized therapeutic

plan (Bernal et al., 2009; Gainsbury, 2017). Bernal et al. (2009) focused on finding a balance between using the evidence-based treatment and cultural adaptation in which the intervention used by the therapist incorporates the culture and language values of the client. Biever et al. (2011) provided information on a program they devised to train practitioners in oral and written Spanish language and Latino cultures so that they had better awareness and competency of these factors in order to provide services to Latino clients. After the 16-week program, Biever et al. (2011) assessed language competence and cultural competence. The authors compared these results to the ones taken when the participants began the program. The results showed an increase in language competence with a moderate increase in multicultural counseling competence due to prior competence.

Costa and Dewaele (2014) explored the practices, beliefs, and attitudes of both monolingual and multilingual therapists in their connections with patients who were multilingual. From the study, the researchers wanted to discover if there were any significant differences between the multilingual and monolingual therapists in their dealings with multilingual clients. They found that one component proved to be significant in the difference between the two types of therapists – attunement versus collusion. While the multilingual therapist was able to help their clients feel more connected by speaking in their native language during sessions, which provided for more intimacy and empathy in their conversations, this also could lead to collusion. Thus, multilingual therapists shared that setting boundaries and providing disclosure for therapy sessions was crucial. For the monolingual therapists, they found that they were less likely

to have preconceived notions about their clients and make cultural assumptions, and thus there was less likelihood of collusion (Costa & Dewaele, 2014).

Karamat (2004) explored bi- and multilingualism in family therapy and discovered a gap in the literature related to family therapy in regard to bilingualism. The author was the therapist in these situations and also provided his experience as a non-native English speaker who did not know the languages of his clients. The therapist/author urged for more bilingual therapists in practice so that the clients' needs can be better met. The bilingual therapist concluded that including culture as the central representation in a family therapy session; then allows for thought, language (both external and internal), emotion, intersubjectivity, and behavior to become more prevalent in a bilingual therapy alliance (Karamat, 2004).

Lebron-Striker (2012) researched the experiences of Spanish-speaking counselors-in-training. The participants shared that having language and cultural knowledge aided in making the client feel more comfortable. The findings of the study produced five significant themes:

- importance of culture
- translation issues
- the practice of counseling Spanish-speaking clients
- positive experiences and future development
- self-assessment with negative

Pedersen (1991) explored multiculturalism as a fourth intervention theory. By providing a broad definition of culture, a therapist could assist a client in identifying

more commonalities than differences when an issue related to culture in a broad sense is presented during the session. Having a broad definition of culture allows for more accuracy by the therapist in regard to matching the client's intention and culturally based expectation with the behavior of the client. A broad definition of culture also assists therapists in being more self-aware of any preconceived ideas of culture which can predetermine an outcome. Culture has been found to provide a significant representation for providing an understanding of others and ourselves.

Suarez-Morales et al. (2010) studied 16 therapists and 235 clients who had similar acculturation and birthplace origin and provided results that indicated that ethnic matching of client and therapist was not a predictor of the clients' success or failure in their substance abuse treatment. The authors found that clients were receptive to speaking with a therapist of similar ethnic background, birthplace origin, and Spanish-speaking as they viewed the therapist as being more empathetic.

Language Proficiency/Competency

Hill (2008) provided a narrative of the therapeutic process between a therapist and a client who both spoke French and English, with the client's native language being French. The client was referred to the therapist because of her language and cultural similarities. However, the client did not want to speak French in session at first. Through many sessions, it was revealed that speaking in French brought back many traumatic events that took place when the client was a child. Eventually, the therapist and client spoke in French once the client worked through the traumatic experiences through

therapy. By speaking French, the client was able to delve into the regressed memories from her childhood.

In a study conducted by Verdinelli and Biever (2013), the authors explored 14 therapists whose native language was English, did not identify as Latina/ a/x and were willing to provide therapy in Spanish to Spanish-speaking clients. Although these therapists spoke Spanish as a second language, they did not receive any formal training in providing therapy in Spanish. From the study, the researchers found that the Spanish-speaking clients' initial doubts about therapy were relieved when their therapist spoke to them in their native language and shared interests in their cultural values.

Confidence in Language and Culture Competencies

Fryer et al. (2012) sought random older citizens from the United States, the United Kingdom, Australia, and Canada who spoke non-predetermined languages and came from various ethnic backgrounds to address healthcare issues that concerned them. The researchers found it challenging to conduct in-depth interviews when they did not speak the same language as the participant and were unable to prepare to speak. The interviewer and interviewee did not share the same culture or language background, and as a result, the interpretative gap was widened.

Nino (2013) focused on the immigrant couple and family therapists' experiences with their immigration and how it could affect interactions with their clients. Trepal et al. (2014) explored the experiences of mental health counseling students who were providing bilingual services to clients. The results of the study revealed that the participants' experiences with providing bilingual mental health services were both

connecting and challenging. The participants would connect with the clients by rehearsing what they would possibly say in their next therapy session in the second language. Yet, they found it challenging to know the appropriate linguistics of the second language as well as the specific culture of the client. Some of the challenges the participants shared in regard to their preparation for providing bilingual services were lack of resources and lack of supervision from a bilingual supervisor.

Verdinelli and Biever (2009a) conducted a qualitative study comprising 13 phone interviews with therapists who were native Spanish speakers and those who were US-born Spanish Speakers or heritage speakers. From this study, the authors found that both types of Spanish speakers felt pride in being able to converse with their clients who spoke Spanish. However, they still expressed the need for further training in bilingual counseling.

Bilingual Training

Stringer (2015) and Ding et al. (2019) reviewed the growing population of Spanish-speaking clients and the need for proper training of culturally competent psychologists. The authors shared that there are only a dozen or so schools that provide training for bilingual mental health professionals. Ding et al. (2019) and Stringer (2015) posited that there is a greater demand for bilingual therapists along with equal interest from therapists to gain the proper training they need. Verdinelli and Biever (2009a) explored the experiences of bilingual graduate students and psychology professionals regarding their supervision in graduate school and their current employment. From the focus group discussions, participants shared that they felt burdened to provide Spanish

language services based on their language competence. Participants also shared that they had very little training and that their supervisors had no Spanish linguistic skills, although they were multiculturally competent.

Verdinelli and Biever (2009b) sought to discover the training needs of mental health professionals who provided Spanish-speaking services to their clients. The findings from interviewing the participants provided insight into the desire for more training and a sense of gratification by being able to provide mental health services in their Spanish-speaking clients' native language as well as, at times, share in the same cultural background which then allowed for a better therapeutic alliance.

Language Switching

Kapasi and Melluish (2015) identified from previous research the influence of switching languages during therapy, the training needs for bilingual therapists, and the emotional facets of language use in therapy. The researchers also indicated the extent to which the therapist explored the client's feelings, thoughts, experiences, and behaviors, as well as being able to speak to them in their native language in order to show an understanding of what was shared with them, indicating language as an important feature of therapeutic alignment. Three themes became apparent in the findings:

- Language use and emotions: Comparison of the emotional experience of language use in both native and second languages, focusing on embarrassment in the predetermined topics for interviews.
- The use and effects of language switching: Language switching could increase the likelihood of the client's self-disclosure and emotional expression.

- Language delivery and training needs: The majority of therapists studied revealed they were self-taught and wanted additional training and support in providing bilingual therapeutic services.

Kokaliari et al. (2013) explored therapists' comprehension of the importance and role of language with bilingual clients. The implications of the study found that therapists recognized the importance of bilingualism and tracking language switching with clients. Clients tend to switch languages when topics shift to topics of death and love. Language can affect transference and countertransference as an enrichment of the alliance between the therapist and client or can affect it negatively, which can cause a rift in the alliance.

Santiago-Rivera et al. (2009) studied therapists and their clients who switched between utilizing English and Spanish during therapeutic sessions. In their study, the authors found that when the therapists switched from English to Spanish when expressing emotions, their clients were more likely to do the same and thus creating trust and better communication.

Walsh (2014) delved into the challenges that the bilingual therapist faces with having to go between speaking and listening to two or more languages and then ensuring that nothing is lost in translation when writing reports in English. Through the author's experiences as a bilingual therapist, Walsh (2014) found that providing therapy in the client's native language can provide both a connection to the client but also can distance the client and therapist, and be a defense mechanism. The author posited that there are many advantages to providing therapy in more than one language and also understanding

more than one culture. The author found that often in bilingual therapy, there are three languages used: English, a second foreign language, and psychoanalytic language.

Importance of Knowing Clients' Experiences

Chang and Berk (2009) explored the experiences of ethnic and racial minority clients in therapy with Caucasian therapists and whether or not race played a role in the therapeutic relationship. Through self-reporting of the client and follow-up interviews, the study by Chang and Berk (2009) found that eight of the clients had a satisfying experience while the other eight did not share the same experience. The majority of the clients were immigrants, with all of them having a command of the English language for the interview to be conducted in English. Biases in the recall of their experiences and limitation in describing their compound experiences were noted in the findings. Hodgetts and Wright (2007) explored the role of the client's experiences and how they contributed to the therapeutic process. The authors concluded that without hearing from a client regarding their experience with psychotherapy, it is not possible to comprehend how therapy can aid the client in changing behavior and to know whether the therapy received was effective or not (Hodgetts & Wright, 2007).

Kokaliari et al. (2013) explored therapists' comprehension of the importance and role of language with bilingual clients. The implications of the study found that therapists recognized the importance of bilingualism and tracking language switching with clients. Clients tend to switch languages when topics shifted to topics of death and love. Language can affect transference and countertransference as an enrichment of the

alliance between the therapist and client or can affect it negatively, which can cause a rift in the alliance.

The study by Marusiak (2012) investigated the experiences and perspectives of four refugees from three different countries who sought therapeutic intervention. The study sought to understand their reasons for seeking therapy, the overall experience of the psychotherapy, their presenting problems, and which facets of the therapy they considered helpful in order to enable change. The results from the study indicated the following experiences and perspectives:

- a strong relationship between the client and the therapist that was based on positivity and mutual understanding.
- an accessible and safe therapeutic environment.
- a review of the client's past along with interventions that included advice, encouragement, and direct assistance with essential life tasks.
- treatment goals provided that correlated directly with the specific client, which addressed relief of symptoms as well as perspectives and circumstances of the refugees' lives.

Client-Therapy Culturally Appropriate Interventions

Chang and Yoon (2011) sought to evaluate the perceptions pertaining to race that ethnic minority clients experienced in their therapy sessions with a therapist who was racially different than the clients. A single self-report questionnaire was utilized, and responses were verified through an interview. The study reviewed responses given by 23 ethnic minority clients who had recent therapeutic interactions with a racially different

therapist. Most of the participants in the study felt that the therapist could not understand their experiences that related to race, ethnicity, or culture (REC). However, if the therapist showed compassion and was visually comfortable discussing REC, then the clients felt the racial differences were minimalized. The results suggested that therapists should acquire a skill set that will allow them to address REC perceptions in order to have a positive impact on the therapeutic relationship (Chang and Yoon, 2011).

Jock et al. (2013) explored the similarities and differences in the manner in which clients from different cultures experience therapy. The participants were former clients who resided in the U.S. and Argentina who went for therapy in their country. Six Argentine clients and six U.S. clients were interviewed after being selected from a sampling based on referrals from contacts of the researchers. Criteria to be included in the study were: 18 years and older, no severe mental illness diagnoses, the outpatient setting for their former therapy sessions, and treatment were ended no more than three years prior. The clients shared a similar reason for seeking therapy, which was anxiety. The notable difference between the two groupings of clients was the intervention used: in Argentina, a psychodynamic style of therapy was used, and in the United States, cognitive behavioral therapy was used. The type of intervention used was a guide to the specific culture by considering the therapeutic intervention that works best for the overarching culture with obvious alterations made to fit the needs of the client.

Meyer and Zane (2013) intended to investigate if clients perceived their mental health treatment was impacted by their ethnicity and race and that of their therapist, as well as if the therapist considered the cultural factors and how they affected the outcome

of their treatment as well as their satisfaction of services received. There were 102 young adult clients who sought care from their private sectored university counseling center and adults who sought care from two public mental health clinics. A questionnaire was given to the participants, which was analyzed using quantitative analysis. “Ethnic minority clients generally felt that issues regarding race and ethnicity were more important than did White clients. “When these elements were considered important but not included in their care, clients were less satisfied with the treatment" (Meyer & Zane, 2013, p. 884).

Owen et al. (2014) explored the clients’ religious devotion and how it may or may not impact the clients’ perceptions of their therapists’ cultural humility and the therapeutic results. Participants completed an online survey and were able to ask questions via email after completing the survey. One hypothesis was that there would be a positive association with therapy results based on a perceived cultural humility. A second hypothesis revolved around the religion/spirituality commitment of the client and that the higher the relevance, the higher the relation between cultural humility and therapy results. The participants in their research were 45 clients whose religious affiliation was the prominent attribute of their cultural identity; 18 were currently in treatment, while 27 had completed their therapy treatment. The results indicated that clients’ perceptions of the therapist’s cultural humility positively affected therapy results. The connection between perceived cultural humility and therapeutic outcomes was positive for clients with a more salient commitment to their religion. Clients with less emphasis on their religion/spirituality had little to no difference in the connection between cultural humility and therapy results (Owen et al., 2014).

Owen et al. (2016) hypothesized the relation of missed opportunities to acknowledge cultural issues having a negative impact on the client's improvement, and if the therapist showed cultural humility, it would have a positive impact on the client's improvement. The third hypothesis involved how the therapist's cultural humility would mediate the connection between client improvements and missed cultural opportunities. The first two hypotheses were proven to be valid through the study. The last hypothesis proved invalid as there was not a significant correlation between missed cultural opportunities and outcomes of therapy.

Owen et al. (2011a) sought to understand the clients' perception of their therapists' multicultural competencies (MCC) via the clients' ratings of their therapists and if the therapists' MCCs affected the process of and the therapy outcomes for their clients. The participant pool was comprised of 143 clients from a university counseling center. Criteria for clients were that they had completed at least three sessions with their therapist. From the 143 clients surveyed using CCCI-R (Cross-Cultural Counseling Inventory-Revised), 31 therapists were identified, and their demographic information was gathered. Ultimately, the results indicated that the clients who shared the same therapist did not share the same perception of the therapist's MCCs. This suggests that the therapists' MCCs are not generalized for a specific culture or race, but rather that the therapists treated each client specifically according to their cultural needs.

Owen et al. (2011b) conducted a study which was a retrospective of a previous study from Owen et al. (2011a) regarding the clients' perceptions of their therapists' multicultural orientation (MCO), how they were connected to the clients' psychological

functioning, and whether relational processes of the therapy may affect the relationship between the client and therapist. In the study, it was explored that cultural issues raised during therapy were not the primary focus of the therapy session. However, the issues might impact the clients' perceptions of their therapists' MCO and thus possibly affect their real relationship. The study found that there was a need for therapists to be considerate of their multicultural awareness and their multicultural knowledge in order to relate to their clients' psychological well-being and thus provide a positive working alliance and authentic relationship. Therapists should also take into consideration cultural factors when conceptualizing the clients' issues and providing intervention that best meets the needs of the specific client.

Summary and Conclusions

Mental health awareness is a prominent concern and continuing to grow in the United States. Among those potentially seeking mental health treatment, the Spanish-speaking population is the second-largest in the United States, with 18.5% of households identified as Hispanic (United States Census Bureau, 2021). Therapists will need to be prepared to provide therapeutic services to Spanish-speaking clients. Part of the preparation for therapists will be to know the experiences of self-identifying Latino/a/x former clients.

In the next Chapter, the design and approach taken for the research methodology will be explained and justified. As well, within the discussion, data sources will be identified in order to answer RQs. Procedural characterizations that will be the basis of

the conduction of the research study will be identified and reviewed. Lastly, considerations for the ethical collection of data from the sources will be outlined.

Chapter 3: Research Method

Introduction

The purpose of this phenomenological study was to explore the therapy experiences of self-identifying Latino/a/x former clients who received mental health services. I also aimed to explore how former clients perceived the use of language in therapy, the therapists' skills in language and cultural competence, and their overall assessment of the therapy experience. Finally, I explored self-identifying Latino/a/x former clients' recommendations regarding mental health therapy.

Research Design and Rationale

In this study, I used a qualitative IPA (see Charlick et al., 2016; Pietkiewicz & Smith, 2014; Roberts, 2013; Smith & Osborn, 2008; Smith et al., 2009) to answer the following RQs:

- RQ1: What are self-identifying Latino/a/x former clients' experiences in mental health therapy?
- RQ2: How do self-identifying Latino/a/x former clients perceive cultural variables such as language and ethnicity in the therapeutic process?
- RQ3: How do self-identifying Latino/a/x former clients assess their relationship with their therapist and the overall outcome of therapy?

Qualitative Research Approach

A qualitative methodology was the most appropriate for the objective of this investigation, as in-depth, self-identifying Latino/a/x former mental health therapy clients' experiences in therapy were intended to be understood through the completion of

this project. This study also aligned with a qualitative approach, given that little is currently known within the existing literature about the personal experiences of self-identifying Latino/a/x former clients.

The steps involved in qualitative research move from "philosophical assumptions, to worldviews and through a theoretical lens, and on to the procedures involved in studying social or human problems" (Creswell, 2013, p. 37). The qualitative researcher gathers the information via field notes, observations, and interviews (Patton, 2002). For the purpose of this study, interviews were used. These data pieces are transformed into a narrative that explores themes, categories, and examples. From these elements, the researcher offers insight and explanation of what was discovered (Creswell, 2013). Qualitative research often makes higher resource demands on a per subject basis than quantitative research due to the complex data gathered (Creswell, 2013). As a result, qualitative conclusions are often drawn from a limited number of reference subjects.

IPA

IPA was selected for this project, given my interest in personal perspectives on lived experiences. IPA refers to the manner that events, people, and objects occur to a participant within their context. The orientation of phenomenology within IPA targets the identification of the fundamental experiences, or phenomena, which make them unique from others' experiences (Pietkiewicz & Smith, 2014; Taylor, 1985). IPA is the ideal qualitative approach because it can provide data concerning the way respondents not only understand but also make sense of the elements of mindfulness as an intervention (Smith, 2003; Smith & Osborn, 2008; Smith et al., 2009). The IPA approach draws distinctions

with the quantitative method, which is primarily based on statistics, making the researcher a removed participant. Such was the case for this study because, as opposed to actively participating in the study to make meaning of the reported data, I was largely independent of the study. The present study was dependent on me as the researcher for my analytic and integrative skills as well as my personal knowledge of the social character of the context of the study (see Smith, 2003; Smith & Osborn, 2008, Smith et al., 2009).

Role of the Researcher

With a qualitative study using IPA, my role as the researcher involved interviewing self-identifying Latino/a/x former mental health therapy clients who went through therapy with a bilingual therapist and then interpreting their experiences. The researcher's role is as a primary instrument for the overall conceptualization of the study (Lofland et al., 2006; Ravitch & Carl, 2016). As an instrument in the study, the researcher's interpretation of the interviews, subjectivity, analysis of the data collected, and engagement with and approach to the participants in the study are all part of the reflexive process involved in the final analysis of the data (Ravitch & Carl, 2016).

There may have been times during the data collection when my past experiences and biases became intertwined in my analysis. Realizing this and considering my social identity (gender, race, ethnicity, languages, and nationality) required me to use a reflexive process throughout the data collection stages (see Ravitch & Carl, 2016). I used a system of journaling my thoughts, experiences, and self-realizations of biases before, during, and after interviewing participants. Ravitch and Carl (2016) posited that an examination of

my biases is an ethical responsibility due to the direct and indirect implications my biases could have had on the participants in the study and in the interpretation of the participants' experiences.

Lastly, to address any ethical concerns that may have arisen for participants in the study, I provided an informed consent document. This document provided participants with the steps that were followed to protect all personal information as confidential. It is the researcher's responsibility to ensure that all aspects of the study are kept confidential and are ethically handled.

Methodology

Population and Sample Type

The population for this study was self-identifying Latino/a/x former mental health therapy clients. In conjunction with using IPA, I used a homogenous sample that provided a proper analysis of differences and similarities in participants' experiences due to the sample type being similar in variables (see Pietkiewicz & Smith, 2014). These participants, as previously described, were pursued in a purposive sampling strategy. A study using IPA maintains its' contextualization by keeping a defined sample measure (Robinson, 2014). Participants were excluded if they were currently in a therapy relationship, had received therapy more than 3 years ago, did not self-identify as Latino/a/x, and if they were are under the age of 18 or over the age of 65. It is the responsibility of the researcher during the planning phase of the study to protect potential participants who are from a vulnerable population and could be affected by the outcomes and process of the research study (Wilson & Neville, 2009).

Participant Criterion

The participants in this study could be male or female, self-identified as Latino/a/x, were Spanish and English speaking, had previously used therapeutic services with a monolingual or bilingual therapist within the past 3 years, were not currently in therapy, and were 18 to 65 years of age. A prescreening survey was given to potential participants to ensure the criteria were met. The sample size for this qualitative study was 10 participants. The sample size for a qualitative study is guided by both practical and theoretical considerations, with interview-based studies using IPA having a range no larger than 16 participants so that the researcher is not belabored with data collection and so that the sample size is better represented as a defined identity rather than becoming an undefined resource in a larger study (Smith et al., 2009; Robinson, 2014).

When recruiting participants in the study, I sent emails to therapists who identified as bilingual in Spanish and English. Within this email, I provided the criteria for participants in my study and the expectations to participate in the study. From these emails, I was provided with contact information for potential participants in the study. I distributed flyers to local agencies and social media private pages which specialized in serving Spanish-speaking clients. I set a deadline of 10 business days in which to receive responses from my initial emailing to bilingual therapists. Once I received a sufficient response from the bilingual therapists, I then sent a prescreening survey to potential participants. I allowed 14 business days for potential recipients to respond to my prescreening survey. After reviewing the prescreening surveys, I scheduled interview times with the participants, which consisted of no more than two interviews per day. If

the recruitment of participants had not yielded a sufficient number, I would have contacted local agencies and bilingual psychologists again to request more potential participants.

If at any time, a participant no longer wished to participate in the study, they could simply notify me of their intent to exit the study. I provided them with a note of thanks for their participation and informed them that because they were exiting the study before completing it, their information and input was not used in the study and was permanently deleted from my data collection. For participants for whom I need clarification on their responses to my interview questions, I contacted them via email first to request a clarification of their responses, and, if necessary, I scheduled another one-on-one interview. Once a participant exited the study, regardless if it was before finishing the study or upon completion of the study, they were provided with a debriefing form.

Instrumentation and Materials

I used six data collecting instruments in addition to myself, the researcher, being an instrument in the study. Those six instruments included the following: a participation screening guide, an informed consent form, a RQ and interview question guide (see Appendix), a debriefing form, an invitation flyer, and an email sample. For the interview, a questionnaire using the RQs outlined earlier in this paper was used as a basis. Because I am bilingual, the invitation flyer was made available in both Spanish and English, which I believe assisted in the recruitment of participants. I asked that qualified participants participate in the study in English; however, if there was ever a time when they found it easier to respond in Spanish, I allowed them to do so. The interviews of participants took

place via phone or Skype. Skype has audio recording capability. For phone interviews, I used a handheld recording device for audio recording. Within the consent form, I included that the interviews were recorded, and I discussed the audio recording prior to the interview beginning. The audio recordings were used solely for the purpose of developing the transcript of the interview to assist with the data analysis process.

These interviews were one on one between me, the researcher, and the participant. After each interview, I took the time to journal my experience and impressions of the interview, allowing for self-reflection. For the creation of emails, forms, and flyers, I used Microsoft Word and Microsoft Outlook to send the emails. For the prescreening survey, I used an email or phone screening. For the coding of interview responses, I used manual coding.

Data Analysis Plan

The thematic analysis allows research in a qualitative method to identify patterns from the participant's responses to the interview questions (Braun & Clarke, 2006). By using thematic analysis, the research in this study was gathered in a succinct manner, providing differences and commonalities in the responses given during the interview process. With thematic analysis, there are six phases in approaching the data. The first phase involved the researcher becoming familiar with the data by reading, then rereading the textual data by listening, and finally by listening again to the recordings; this allowed for total immersion into the data (Braun & Clarke, 2012). The second phase involved systematic analysis through coding of the data. Codes are meant to be a form of shorthand for the researcher to understand. As the researcher worked their way through

the data, coding themes emerged, which gave way to the third phase of thematic analysis – the search for themes (Braun & Clarke, 2012). This phase comprised the review of coded data so that intertwining between codes and identification of similarities within those codes can be evident. In Phase 4, all potential themes are reviewed in relation to the complete data set as a form of quality assurance. The phase is important in identifying the true, meaningful capture of themes within the coding. According to Braun and Clarke (2012), Phase 5 allowed for the definition and naming of themes in which the researcher needed to clearly state the specificity and uniqueness of each theme. Phase 6 of thematic analysis provided the production of, in this case, the dissertation study. Braun and Clarke (2012) posited that "the purpose of your report is to provide a compelling story about your data based on your analysis" (p. 69).

Issues of Trustworthiness

A significant challenge for researchers using qualitative methodology is to provide the highest possible quality when conducting a research study (Cope, 2014). An important concept of a qualitative study is trustworthiness. Trustworthiness applies to the virtues of credibility, dependability, transferability, and confirmability within a researcher's qualitative study (Given, 2008; Stahl & King, 2020). These virtues provide a tool from which a researcher can exemplify the value of their study outside of the constraints of quantitative parameters (Given, 2008; Stahl & King, 2020).

Credibility

Given (2008) postulated that the basis for credibility in a research study is that both the researcher and the reader can make sense of the research design. Credibility

indicates the validity of the data or how the research represents and interprets the views of the participant (Cope, 2014; Rutberg & Bouikidis, 2018). Within this study, the researcher needed to ensure that appropriate participants who were to provide thorough and honest responses were selected and that an appropriate method for data collection was used. Through journaling their experience with rich, thick descriptions, the researcher provided credibility to the participants when they verified their findings.

Dependability

The value of dependability can be best measured by keeping a thorough, chronological audit trail, which includes research processes and activities, data collection and analysis influences, emergent themes, and analytic memos (Rogers, 2018). Within this study, the audit trail consisted of recorded interviews, summaries of data analysis, and notes taken throughout the data collection process. By providing an audit trail, the researcher allows the study to be easily replicated with similar conditions and similar participants, thus deeming the study dependable (Carcary, 2020; Cope, 2014).

Transferability

A study is considered transferable if the findings can be easily relatable and provide meaning to individuals not directly involved with the study. Within this study, the researcher provided abundant information about themselves as an instrument in the research, in addition to a thorough discussion of research processes, context, participants, and the relationship between the researcher and participants, to allow the reader to decide how the findings may transfer to them. , While the researcher may offer suggestions for

transferability, it is the reader's judgment if the findings of the study are transferable to another context (Elo, Kääriäinen, Kanste, Pölkki, Utriainen, & Kyngäs, 2014).

Confirmability

The ability to recognize that researcher bias can affect objectivity in qualitative research is important to the confirmability of a study. The researcher needs to remain as true as possible to the findings, data collected, and processes followed. Many processes used to complete the goal of dependability are also relevant with confirmability, in particular, being accountable through the audit trail, and being subjective (see Morow, 2005). Through reflexive journaling after each interview conducted with participants, I identified my biases and documented them as part of the audit trail. In reporting the data collected from participants, it was also important to provide detailed quotes which represent emerging themes (see Cope, 2014).

Ethical Procedures

For voluntary participation in this study, individuals meeting inclusion criteria were invited. The inclusion criteria consisted of self-identifying Latino/a/x former mental health therapy clients, ages 18 to 65, nongender specific, who met with either a monolingual English-speaking or a bilingual Spanish-English speaking therapist and were currently not under the care of a licensed mental health therapist. Ethical concerns considered were recruitment of participants, data collection, management of data, and protection of data.

Recruitment

I submitted the Walden University Institutional Review Board (IRB) form before conducting any data collection for the study. This form reviewed all ethical

considerations for the study, which was approved by the IRB. Participants in the study were not forced to participate in the study. I provided potential participants with sufficient information so that they made an informed decision regarding their participation in the study. The invitation flyer and participant screening guide presented to participants indicated the purpose of the study and a description of the criteria to be considered for participation. In the consent form, a statement of confidentiality, potential risks of participating in the study, benefits of participating in the study, the interview process as well as the approximate length of the interview, communication methods that were used, and acknowledgment of information regarding the audio recording of the interview were provided to all participants. I discussed with participants their right to cease all participation in the study at any time, should they have desired to do so. The consent form provided a written communication of early withdrawal from the study being allowed without any negative treatment towards the participant.

Data Collection

Within the consent form, I provided easy-to-read instructions and information so that participants could make an informed decision to participate in the study. Participants could ask questions regarding the consent form, and the overall research process, at any time. Participants were given the researcher's contact information, as well as Walden University's Participant Advocate Department should they have questions regarding participation in the study. Confidentiality and protection of identity were addressed in both the consent form and during the data collection process. The participant's personal identification was given a pseudonym in place of their actual name. All documentation

kept by the researcher – audio recording transcripts, audio recording tapes (if the tape recorder is used), and the final write-up of the findings – also protected the identity of the participant by using their pseudonym or assigning a number.

Management of the Data

All data collected for the purpose of the study was kept confidential and was only released with the expressed, written consent of the participant. Walden University's IRB provided permission for the data collected to be released. Each participant's information, as well as any identifiers, was kept confidential and not included in the final write-up of the study. I used a password-protected, online third-party transcription service to assist with transcribing all interviews. Other parties who were privy to the data were the researcher's two Dissertation Committee Members and Walden University's appointed University Research Reviewer (URR).

Protection of the Data

All hard copies of data collected, information, and any materials or forms collected for the study were kept confidential and secured in a locked file cabinet in the researcher's locked home office. All electronic copies of related material in Microsoft Word, Microsoft Excel, or other software used were password-protected files on a password-protected computer and on a password-protected thumb drive, kept locked in a private file cabinet in the researcher's locked home office. As required by Walden University's IRB, all data is kept for a minimum of five years before being destroyed. Information regarding data retention and disposal was clearly stated on the consent form provided to the participant.

Upon completion of the study, participants were provided with the results. A participant may request a final copy by contacting the researcher via email, which was indicated on the consent form. As well, the option of receiving a copy of the final study was communicated to participants prior to their agreement of being part of the study.

Summary

In this Chapter 3, a review and description of the qualitative research design and research tradition, IPA, was provided. An explanation of how the RQs were applied using IPA was specified. Also included in this Chapter was a review of the role of the researcher, data collection methods, and procedures for recruitment, participation, and data collection. The processes for data analysis, participant selection, concerns of trustworthiness, and the ethical procedures for data and participants were examined in Chapter 3 as well.

The potential for researcher bias and the necessity of recognizing the bias was discussed in this Chapter. To better manage the potential for bias, I need to acknowledge that I may have a bias toward the topic of this study due to my educational and professional background. I began speaking a foreign language (Italian) when I was a young child at home. Through my education, I learned four additional languages and lived and studied abroad in Spain. In my professional background, I previously taught Spanish and French language and culture. I continue to have almost daily interactions with native Spanish-speaking students in my current employment as an Academic Coach. I am passionate about continued education and daily use and understanding of the Spanish language and culture. I recognize that my interest in, and advocacy for, the

potential participants' experiences with bilingual mental health professionals may cause some bias on my part. A reflexive journal was kept so that I could examine my thoughts of bias should they have arisen. If a bias was recognized, I addressed it through collaboration with my Dissertation Committee Members.

In Chapter 4, I describe the data collection to answer the RQs for this study. Once the collection was satisfied, Chapter 4 allows for the organization of the data and report of the findings.

Chapter 4: Results

Introduction

The purpose of this phenomenological study was to explore the experiences of self-identifying Latino/a/x who received mental health therapy. In the study, I explored how self-identifying Latino/a/x former mental health clients perceived the use of language in therapy, the therapists' skills in language and cultural competence, and the participants' overall assessment of the therapeutic experience. I also explored self-identifying Latino/a/x former mental health clients' recommendations regarding mental health therapy. The following RQs helped to guide the interview process with the study's participants.

- Research Question (RQ) 1: What are self-identifying Latino/a/x former clients' experiences in mental health therapy?
- RQ2: How do self-identifying Latino/a/x former clients perceive cultural variables such as language and ethnicity in the therapeutic process?
- RQ3: How do self-identifying Latino/a/x former clients assess their relationship with their therapist and the overall outcome of therapy?

In this Chapter, I provide data collection, data analysis, and the results of the study. This Chapter also includes an explanation of significant factors that helped guide these processes, and a comprehensive description of the study participants, including demographics and the setting. Finally, I discuss the themes and subthemes that occurred within the data collected from self-identifying Latino/a/x former clients who shared their experiences. In the first section of this Chapter, I describe the data collection process,

including how participants were located, the screening process, compensation to participants, and the transcription methods used with recorded interviews. The second section provides the strategies I used for coding the data and the themes that emerged from the data analysis. In the third section, I share the measures for the credibility of the data, and the final section is a summary of the findings.

Participant Selection and Data Collection Process

The initial IRB approval for this study was received on January 15, 2020 (# 01-15-20-0333087). At the time, I sought participants who were bilingual Spanish–English former clients who had received mental health services from Spanish-speaking therapists. I began immediately sending emails to licensed mental health professionals I found across the United States through Psychology Today's database. I sent out over 300 emails and received approximately five responses, all of which informed me they knew of no former clients they could share my study with. In March 2020, the Covid-19 pandemic led to office closures, social distancing measures, and a shift from in-person mental health therapy to teletherapy. Therefore, my intention to find local mental health facilities to visit and share my study's flyer was not possible. Because of the pandemic and lack of responses from bilingual therapists, I sought approval from IRB to change my participant recruitment method.

On April 4, 2020, I was granted approval by the IRB to shift my recruitment methods to using specific groups on social media, specifically my personal Facebook page, and through snowball sampling. Chambers et al. (2020) provided an example of

how to snowball sampling for their study increased the number of participants more than placing an ad on Facebook did:

> Previous studies suggest that social media can be a successful and cost-effective sampling strategy, increasing the numbers of participants, their diversity, and their representativeness of the population of interest. This study, however, found traditional snowball sampling to be far more effective than advertisements via Facebook and a professional website. (p. 846).

I posted my flyer to Facebook on my personal page and within specific Facebook groups, and I asked friends, family members, colleagues, and group members of those Facebook groups to share my study with anyone they thought would qualify (snowball sampling). The following Facebook groups granted me permission to post to their pages: Latinx Therapists, Hablamos Español, Practicamos Español, Spanish Teachers Working Together, Ph.D. Women's Network, Latinx Counselors and Therapists Learn Practice and Speak Spanish and English with Native Language Speakers, Spanish Conversation, Spanish/English Language Exchange, Spanish Translators and Interpreters Association, and Bilingual Mental Health Professionals. I received four messages from people interested in participating. I sent them my screening questions to ensure they qualified, but I never heard back from any of them. I reached out to them a second time to ask if they qualified and would participate in my study, but again I received no responses. I continued to post on Facebook and request snowball sampling for 6 months, but ultimately, I elicited no participants.

On June 17, 2020, I was approved by the IRB to add my study to Walden University's Participant Pool. I was able to find one participant from the pool, and I interviewed that participant in August 2020. Due to the lack of interest despite the new recruitment methods, my dissertation chair suggested I change my topic slightly and request approval from IRB to use Craigslist and offer compensation to participants. On September 15, 2020, I returned to the IRB with a new request to change my topic and to post my study on Craigslist. My new topic was now to find participants who self-identified as Latino/a/x and had attended mental health treatment with a licensed professional who was either monolingual or bilingual. This new topic and recruitment process were approved by the IRB on September 30, 2020. I was allowed to post on Craigslist and offer compensation of a $20 Amazon gift card to each qualified participant. I posted an ad on Craigslist in New York City (Bronx borough), New York; San Antonio, Texas; Houston, Texas; Los Angeles, California; and Miami, Florida. I received 30 responses from Craigslist and interviewed 10 qualified participants.

Between Walden University's Participant Pool and Craigslist, a total of 11 participants were interviewed between August and October 2020. Interested people who felt they qualified for my study emailed me with their interest, to which I responded by email with my participant screening questionnaire and informed consent form. Once I received their responses to the participant screening questionnaire and their consent to participate, I emailed them to ask for their availability to speak on the phone using Unlimited Conferencing. Then, I scheduled the appointment and sent them the call-in phone number and pin via Unlimited Conferencing.

At the start of each interview, I introduced myself and asked my prescreening questions to verify that the participant qualified to participate. One scheduled participant did not qualify to participate, so their interview was not used in the study. Once I established participants were qualified, I verified their email addresses and sent them their $20 Amazon gift cards electronically. I asked if they had any questions before beginning the recording. I notified each participant that I would begin the recording using the Unlimited Conferencing recording capability. As a backup recording device, I also used the Voice Memo feature on my personal cell phone. The Unlimited Conferencing software required me to sign up for a membership using a password-protected login to the secure site. The Voice Memos were locked and saved with a password on my cell phone. On the Unlimited Conferencing software, the audio recordings were saved as MP3 files. I named each recording with the participant's numerical pseudonym and the date of the interview to protect the identity of each participant. I asked each participant the interview questions according to my interview guide (see Appendix). I kept notes on each interview and then stored these handwritten notes in a locked cabinet in my home office. At the end of each interview, I advised the participants that the interview was over, and I stopped the recording.

During the interviews, I was able to deviate from the structured questions at times when there was a natural digression. This deviation allowed for more robust conversations with some of the participants and helped me gain a deeper understanding of their experiences in mental health therapy. There were also instances when I could relate personal stories with my language and cultural experiences and used my Spanish

language skills. During those situations, participants seemed to be more comfortable with our conversation by relating to them on a personal level. After I finished asking my interview questions, I inquired from participants if there was anything further they would like to share with me about the experiences that they felt would benefit my study. Some of them offered more information, but most did not. I also advised each participant that if they thought of anything after our conversation and would like to share, they were free to email me. I did not receive any follow-up emails from the participants. Before ending the call, I advised each participant that if there was anything I wanted to ask or if I needed clarification on anything that they shared with me, I would contact them via email to ask for another phone call. I never had to follow up with any of the participants as my notes and recordings were clear. Interviews were concluded when I felt the participants had provided me with all the information, and the conversation was naturally ending. On average, each interview lasted 30 to 40 minutes.

As I proceeded through the interviews, I became more comfortable with my interview questions and eliciting responses from participants, which allowed me to be more precise with my line of questioning. I recognized that patterns began to emerge in my perception of the participants' recollections of their therapeutic experiences. After each interview concluded, I made a note of my initial perceptions and reactions that I felt might be relevant during data analysis. I kept my collection of initial reactions on paper, locked it in my office file cabinet, and then I typed the notes and saved them on a password-protected flash drive.

After each interview's recording was available on Unlimited Conferencing, I took the MP3 files and uploaded them to Trint, a fee-based, computer-generated transcription service. IRB approved the use of Trint's services. I registered and paid for Trint's services using a password-protected, secure login. Once the transcription was complete on Trint, I reviewed the transcripts to ensure proper transcription of each conversation. As I read through the interview transcript, I listened to the recording. If I noticed discrepancies between the recording and the transcription, I highlighted and revised the transcription to the correct wording. The transcription service could not translate Spanish words. Many times, I had to revise the transcription to the correct Spanish words from the interview. I never deleted or altered correct transcription in any parts of the conversations, as I did not want to destroy contextual information. No one outside of my dissertation committee has listened to the recordings or read the transcriptions from the interviews.

Coding Data into Formatted Coding and Thematic Analysis of the Data

I used Unlimited Conferencing software to record and save the interviews as MP3 files. After Trint transcribed the recordings, I reviewed each transcription for accuracy. I found many errors in the automated transcription, and each interview took approximately 2 hours to verify transcription. To maintain the credibility of the data, I ensured each transcription was accurate to what was said in each interview.

After completing each interview, I handwrote my initial reactions and then typed them. Memo writing is a gateway between coding to the final analysis of the data because it allows a researcher to expand on the actions, processes, and assumptions incorporated

into the code (Charmaz & Thornberg, 2021). Charmaz and Thornberg (2021) found that researchers could be more entuned with the coding by memo writing because they then see coding as a way to explore processes as opposed to simply sorting data into topics.

Demographics

Participants were recruited based on their self-identification as a Latino/a/x, not currently attending mental health therapy, but having had participated in mental health therapy within the past 3 years with either a monolingual or bilingual therapist. Participants were found via Walden University's Participant Pool (n = 1; San Antonio) and Craigslist ads in the following cities: San Antonio (n = 1), Los Angeles (n = 2), New York City (Bronx borough; n = 6), Houston (n = 0), and Miami (n = 0). All 10 participants self-identified as Latino/a/x and indicated their Latin ethnicity as Mexican (n = 2), Dominican (n = 2), Puerto Rican (n = 2), Salvadorean (n = 1), Panamanian/Mexican (n = 1), Venezuelan (n = 1), and Afro Latina (n = 1). The 10 participants fell into one of three age groups: 19 to 29 (n = 5), 30 to 39 (n = 4), and 40 to 50 (n = 1). The participants varied in relationship/marital status at the time of data collection: single (n = 7), married (n = 2), and in a domestic partnership (n = 1). One participant indicated she was previously divorced but was currently married; this was relevant because the participant indicated the ex-spouse was one of the reasons she attended therapy. The participant demographic information is displayed in Table 2.

Table 2

Participant Demographics

Pseudonym	Age	Latino/a/x ethnicity	Marital status	Residence
Suheily	26	Puerto Rican	Single	San Antonio
Sophia	47	Afro Latina	Domestic partnership	New York City
Sharin	30	Dominican	Married	New York City
Harris	28	Panamanian/Mexican	Single	Los Angeles
Marilyn	19	Salvadorean	Single	New York City
Jianee	23	Dominican	Single	New York City
Ross	30	Mexican	Single	Los Angeles
Lilly	34	Puerto Rican	Married	New York City
Raul	24	Venezuelan	Single	New York City
Sonia	31	Mexican	Single	San Antonio

During the interviews, I asked participants about their home life situation and who lived within the home, and their ages (see Table 3). Participants who lived with their parent(s) or their parent(s) lived with them were (n = 7). This proved to be relevant because many participants shared that their homelife dynamics were one of the reasons they attended therapy (n = 6). Participants' parents' culture was discussed during therapy by five of them, who shared that their parents' cultural upbringing and norms affected their way of living. One participant shared that their parent did not include their cultural background and language in their upbringing, thus making the participant feel their heritage was not important.

Table 3

Participant Homelife Dynamics

Coded name	Homelife dynamics
Suheily	Lives with parents, 2 sisters, and her daughter
Sophia	Lives with a domestic partner and their son
Sharin	Lives with husband, son, daughter, and mother
Harris	Lives with parents and roommate
Marilyn	Lives with parents and brother
Jianee	Lives with mother, brother, and sister
Ross	Lives alone
Lilly	Lives with her 4 children
Raul	Lives with parents and brother
Sonia	Lives with parents, sister, and brother

Although the therapist's language skills, more particularly if they were bilingual in Spanish and English, was not a requirement of the study, their language skills were relevant considering that all but one study participant spoke both Spanish and English at home and, most times, during therapy. Table 4 represents the therapist's language skills. Because some of the participants had more than one therapeutic alliance within the past 3 years, those participants have each therapist's language skills listed.

Table 4

Participant's Language and Therapist's Language Skills

Coded name	Participant language(s)	Therapist(s) language(s)
Suheily	Spanish and English	Both therapists spoke Spanish and English
Sophia	Spanish, English, Italian	One spoke English and Spanish; One spoke English
Sharin	Spanish and English	English

Harris	English and Spanish	Spanish and English
Marilyn	Spanish and English	English
Jianee	English and Spanish	Both therapists spoke English only
Ross	English	English
Lilly	Spanish and English	All 3 therapists spoke Spanish and English
Raul	Spanish and English	One spoke English and Spanish; One spoke English
Sonia	Spanish and English	One spoke English; one spoke English and Spanish

Note. The first language listed = native language.

Evidence of Trustworthiness

The term trustworthiness is used in qualitative studies to indicate whether a research study and the claims derived from it are warranted and worthy (Levitt et al., 2017). Trustworthiness in a research study allows readers and researchers to be convinced if the study has captured a significant experience (Levitt et al., 2017). Willig (2019) found that readers should be able to understand the researcher's critical reflection and interpretation of the data collected to determine the trustworthiness and evaluate the quality of the study. To demonstrate the trustworthiness of this study, I applied credibility, dependability, transformability, and conformability.

Credibility

Kline (2008) shared, “When reviewers and readers understand the analytic process, the researchers’ expertise, and the rigor involved in the analytic process, they are more likely to regard the research as credible” (p. 6). Throughout my study, I kept a reflective journal. The reflective journal allowed me to document the dissertation process

and recognize my feelings, thoughts, and experiences. By keeping this record, I had a consistent view and review of my study as I completed the various stages involved in the study process. As I progressed through each interview during data collection, I would share at the end of the interview the reason I was asking the questions that I did (purpose of my study). Many of the participants shared with me that they were glad that I was conducting the research because it will help improve mental health therapy for the Latinx population. By sharing their opinion on my study, it provided validity to work I was conducting.

Dependability

When providing a robust, detailed explanation of processes, it allows for replication or expansion of a study to be easily produced by other researchers, which addresses the dependability of the study (Shenton, 2004). To ensure my study included the value of dependability, I recorded interviews, summaries of data analysis, and notes taken throughout the data collection process, which provided an audit trail. Through the processes during and after data collection, I was able to compare information in order to find similarities. The emergence of themes was identified through these thorough processes, which then provided a better understanding of the phenomenon.

Transferability

The construct of transferability refers to the data and how it establishes the context of the study while allowing readers and other researchers to compare the study to themselves or others (Shenton, 2004). Self-identifying Latinx persons, monolingual therapists and bilingual therapists who have Latinx clientele, and therapists who have

clientele from any culture/ethnicity different than their own can relate to the findings in this study. I provided detailed information on how I recruited participants for the study, sample size rationale, sample type, and participant demographics to allow readers of this study to transfer information to their own situation. I created several tables of demographics related to this study which can promote the transferability of information and the outcome to the readers.

Confirmability

Confirmability can be defined as objectivity in a qualitative study (Shenton, 2004). To address objectivity in this study, I wrote in my reflective journal after each interview so that I could recognize if any of bias(es) were revealed and then address and understand why they came to fruition. The triangulation of the study, derived from the diversity of participants and review of data (audio recording, transcription, and reflective journaling), provided the context in which to reduce the effect of researcher bias (Shenton, 2004).

Themes

Data analysis for the study was completed by using a thematic analysis approach. The thematic analysis allows research in a qualitative method to identify patterns from the participants' responses from the interview questions (Braun & Clarke, 2006). After analyzing the data, the three RQs, along with the interview guide, were able to be answered by the 10 participants. From their responses, I was able to identify three themes. The first theme that emerged was attending therapy and therapist selection. The second theme was a positive outcome of therapy or factors that worked in therapy.

Factors participants identified that helped therapy work was: relationship with a therapist, learning how to cope with depression, anxiety, stress, family member(s), therapist's language skills, therapist's cultural competence, and therapist's gender and age-matched/close to the client. The third major theme was therapy that did not work or challenges in therapy. From this theme, the evident factors were the therapist's lack of cultural competence, the therapist's different gender/age with the client, and the therapist's biases about culture. The RQs and the emerging themes are presented in Table 5.

Table 5

Themes and Participants' Responses by Research Questions

Research question	Themes	Examples of participants' responses
RQ1: What are self-identifying Latino/a/x former clients' experiences in mental health therapy?	Reasons for attending	P1: Prior to that was a formality in a way suggested by the military for us to go in as a family to understand my dad's diagnosis of PTSD and bipolar disorder and on develop ways to cope with that and help him. P5: Yeah, like a different a life where occurrences happen to me at the time and I was going through death in the family. Like a traumatic accident and operation. Yeah, it was by recommendation of the coverage of insurance, I had the hospital.

Research question	Themes	Examples of participants' responses
RQ2: How do self-identifying Latino/a/x former clients perceive cultural variables such as language and ethnicity in the therapeutic process?	Challenges or things that did not work	P1: There were some instances where I felt very misunderstood. I felt like certain cultural norms and values were being forced down my throat. I very much felt like there were certain things, like a mindset that was being forced into me that I can't agree with. So it was difficult for me in certain stages. Really, she very much focus on those gender roles. And as an as the eldest child, I didn't agree with that because I'm I grew up to be very independent. P7: She was white, she was Jewish, and there were just a lot of things she just did not understand about my life and she was just very critical and just kind of felt like it was her way. And I almost felt like it wasn't therapy anymore. It was just, you know, kind of her judgment and felt like her own bias kind of playing into that because she didn't have the cultural context to truly understand how that trauma.
RQ3**:** How do self-identifying Latino/a/x former clients assess their relationship with their therapist and the overall outcome of therapy?	Positive outcome or things that worked	P4**:** I felt like good like to have that level of competence to speak with the person that's bilingual and able to understand. Well, I liked yeah, very much that I did. I actually was able to have a bilingual therapist that really helped me a lot.

Theme 1: Attending Therapy and Therapist Selection

One of the emerging themes from the study came from the reasons that participants attended therapy and how they found the therapists they met in the past three years. It was important to know the reasons behind their need for mental health therapy and how they found the therapist because it provided contextual information to the study. Participants shared many commonalities for their reason to attend therapy, including depression, anxiety, coping skills, stress, family, and life in general.

Amongst the ways that participants found the therapist(s) they worked with, they shared the following: general search in an online directory in which they looked for specializations or location, covered by their insurance, court appointed, work appointed, and word of mouth recommendation. From participants regarding their reasons for attending and how they found the therapist(s) included some of the following:

P3 shared,

> I was also getting very overwhelmed with taking care of her (mother). So for that reason, I started looking out to see where I would be able to get some sort of help, because it was I was very, very overwhelmed and I didn't know what to do. I didn't know where to go. And I was like very limited time at home because I was trying to make everything happen during the time that my daughter would be in school. So, OK, since by chance of nature, my college was actually right next to my daughter's school.

P7 also stated,

> Well, so the general idea was just relating around depression and, oh, just mood regulation, say to cut like difficulty to managing, I guess just my like depression level and PTSD. I went on this like medical app that basically outlines kind of all the types of doctors you would need. So you'd like to just search for the type of doctor, that type of kind of health service you're looking for. And then you put in your insurance, and it lets you know all of those that are in network. And then you can see their reviews and what they specialize in. And you know what that client has said about them, obviously anonymously. But, yeah, you can kind of set up a meeting and see how you feel. And so that's how I went about that.

P8 added,

> I was having some general issues with anxiety around my family and my job. So, I was wanting to see some therapy about those issues. So, I did it online search through my insurance providers portal. And I probably called like 30 or so people, until one of them said they actually had availability. And then I just went to them because I was tired of calling so many people. It worked. They were very helpful.

P10 explained,

> I had been arrested. So, the judge ordered me to like participate in the classes I went to a center and they gave me therapy as well. It all was to cover my depression. And all the symptoms I had like lack of sleep and energy. I couldn't go with people in like my own family, so I was there to seek her help. Talk to professionals because I mean, I can only deal with so much until sinking. I've

always had like an open I was like always open to therapy and stuff. I think it's fair.

The first theme that emerged from this study was the reasons behind selecting the therapists with whom the participants met, along with the reason behind attending therapy. The participants provided a general reason for choosing to attend therapy, with many of them needing to learn life coping skills to deal with depression, stress, familial relationships, and anxiety. Most of the participants shared that they did an online search for therapists in their area who took their insurance and provided therapy for their specific reasons, while some asked friends for a referral or were appointed a therapist by the court system or military selection.

Theme 2: Positive Outcome of Therapy/What Worked

The next emerging theme of the study was the positive outcomes from therapy or what worked. The questions asked during the interviews with the participants allowed them to express what they feel worked well during their therapy sessions. The factors the participants perceived as helpful in contributing to a positive outcome in therapy included the therapists' cultural competence, language skills, age/gender of therapist similar to the participant, therapy outcome, and learning how to cope with the reason(s) for needing therapy. There were more reasons provided by the participants for things that did work during their therapeutic experience than things that did not work, which will be discussed in the next emerging theme.

Participants did not verbally express that having a therapist speaking both English and Spanish, sharing the same or similar cultural background, or matching in gender and

age were contributing factors. They did express how helpful it was when their therapist allowed and understood language switching, asked about their culture (showed a genuine interest), shared the same or similar cultural background, and were of the same gender and close in age to the participant. All these inferences contributed to them having the positive outcome from therapy in which they learned how to cope with their reasons for attending therapy. Representations from participants regarding the positive outcome or what worked were expressed in the following ways.

Culturally Competent Therapist

A culturally competent therapist was perceived by participants in this study as a one who could speak to the participant about their cultural background and norms with knowledge that was evident. A culturally competent therapist was also perceived by participants as a therapist who would ask probing questions about the participants' culture to learn about the norms and practices within the participant's family or upbringing. A culturally competent therapist was also perceived as a therapist who researched information on the participant's culture and then shared something they learned with the participant and asked them to share their experiences.

P8 stated,

> Because she was Puerto Rican as well. She knows about. It definitely helped because when I explain to her what happened, she helped me out. I guess like when you find someone that's been going through the same thing you do, you just try to help them out as much as you can.

P9 explained,

> But with the bilingual one, I ended up like real good. You know, I felt way better. I passed over the depression and I just felt like he did it really did his job. He helped me through everything was a real nice experience with that, with him. Because at first he said I didn't need medication. It was something that surprised me. He said I wasn't someone that need them that I only need to change a few things in my life. And with that, I will get over it. You know, with naturally I wouldn't need medication. That something that made me happy, something that was all right. This person really knows what he's doing. The bilingual one was really interested in my culture. You know, I felt like I have somebody that really cared about me working with me there. I felt like a person who have taken the time to speak Spanish to me, being interested in what I used to do in my country and how my country like, listening to my or asking some words in my way, in my accent to say my way of speaking. And the fact that he was interested in my culture. He used to Google it because every time that I went to the session, he was talking to me about something that he investigated and asked me about that. that's when I realized that he was like he took the time to investigate that in his free time, just to talk to me about something that I think that he was doing that to, you know, to make me feel more comfortable about it and that he was really trying there.

Finally, P6 shared,

> I think it's easier to be open to medication when you have someone who has similar backgrounds, at least like even if it's not immediately from the Latino

> community to someone from the Caribbean community that understands just the cultural components and how that can play into it.

Language Skills

Participants in the study perceived their therapist's language skills by them speaking to the participant in Spanish and English, and or by listening to the participant switch languages and then verifying that they understood what the participant said to them by asking questions and providing commentary of what was said to them. Participants shared they could tell if Spanish was the therapist's first or second language, or if they were not native speakers, by listening to their accent.

P1 commented,

> Wonderful. She was so understanding, so respectful, she kind of like blew my expectations out of the water because she understood a lot of the cultural values and factors that were influencing my anxiety. And she really took that into account and helped me find ways that I could cope with my anxiety and the triggers and everything like that with like incorporating what I had told her. So I felt very understood. Mind you, she was not a native Spanish speaker. She had to have the accent. But she understood the saying when I spoke Spanglish to her. And she was just very informative. She mentioned a lot of different things in Spanish that sometimes aren't translatable to English. Which made me feel at ease, comfortable.

P4 added,

> I felt like good like to have that level of competence to speak with the person that's bilingual and able to understand. Well, I liked yeah, very much that I did. I actually was able to have a bilingual therapist that really helped me a lot. And I feel like I maybe if it would have been a different background than mine, I could have maybe been a little difficult for them to understand me or would have been a lot more process of probing and questioning to understand a little bit because of the whole feels better that way. Like when I'm able to communicate both languages because I could just speak Spanish and communicate exactly what I feel and sometimes I'm able to say it.

Age and Gender

Participants perceived the gender and age of their therapist based on outward appearance. According to participants, they felt they had a better experience with their therapist when they shared gender-type and were closer in age. The participants who shared similar generations as their therapist felt that the therapist could better understand what they were going through. The same gender was mentioned as well because some participants had issues that were related to their gender that they felt a same-gender therapist could better understand.

P7 explained,

> You know, people, people that are in my age range and things like that. I think most people probably like, oh, I don't really understand why they're doing X, Y or Z or why things happen for younger people like that. I thought he did a really

> good job and just kind of understanding what I was going through. And to me, I think that was important.

P8 asserted,

> And the social worker was 40 something recently moved from Puerto Rico as well. So, I guess we shared similar things. So, I kind of bonded her. Plus, she was a woman. Maybe that something had to do with that as well. She understood me better.

Learning How to Cope With Reasons for Attending Therapy

The reasons for attending therapy and learning how to cope with those reasons were identified by participants as one of the factors towards defining their positive therapy outcome.

Specifically, participants valued feeling that they had an outside source of support, the therapist was able to work with them to get the right medication, the therapist helped them to achieve a new mindset, they learned how to cope with losing their job, and making peace with violence from past experiences. Many participants mentioned that they attended therapy to have a better understanding of the depression, anxiety, or stress they were having in their lives, and were able to receive skills to help them improve their quality of life.

P4 shared,

> So, at that time when I was able to meet with my therapist, I felt as though I had an outside source of support where I could speak to someone about not just my current issues, the previous issues, if something were to pop up. I was able to

> make peace and my amends with a lot of things that had previously happened so that I could actually focus more on the present.

P6 stated,

> And I think the great thing about her was she was just understanding of that going at high pace. And what's it like throwing medications at me. But it was very communicative and she kind of let me know about each thing she was giving, why she was giving it. She wasn't starting with like a crazy dose.

P10 described,

> I was in a much better place for like mindset, and I feel like I got to take a huge load off me. I didn't feel worse, and it hasn't gotten as bad as it was then. I feel like it really did change my life.

Within the second theme, participants expressed what specific factors made their therapy a positive experience. Many of the study's participants had several therapists they met within the past three years and could extract what was positive and negative from those experiences. Because of the multiple experiences many of the participants had, a more robust view of the positive outcomes was provided for the study. Overall, participants who had positive outcomes from therapy indicated they left therapy on good terms, feeling better about handling life's stressors, and able to face challenges with a new perspective.

Theme 3: Challenges in Therapy/What Did Not Work

The last emerging theme from the study was the challenges that the participants experienced during therapy, or things they felt did not work well in the therapeutic

experience. The participants provided several reasons for why they experienced challenges during therapy or specific reasons for what did not work well for them during their therapy sessions. When participants were asked to share their thoughts on their therapist's cultural competence, regardless of if they spoke to them in English or Spanish, a common negative theme emerged. The therapists who either showed no interest in learning about the participant's cultural background or had a bias about the participant's cultural background, provided an experience that did not work well for the participants. Study participants also shared when the therapist was not of the same gender or close in age, they felt there was less connection between them.

The experiences the participants shared during the interviews provided reasons such as the therapist's cultural incompetence, a difference in cultural background, the therapist's biases about culture, and a difference in age or gender. Participants' vignettes of their experiences can be found in these examples:

Bias of Culture

Participants shared their therapist had preconceived cultural bias which they would share during therapy sessions, and this would make the participant feel upset and angry. The participants shared that they felt that the therapist would not listen to them without judgement. The participants also shared that they felt the therapist was trying to force them to change their cultural identity to believe what the therapist did about the culture.

P1 explained,

> I felt like certain cultural norms and values were being forced down my throat. Yeah. Well, yeah, I. I very much felt like there were certain things, like a mindset that was being forced into me that I can't agree with. So. It was it was difficult for me.

P9 claimed,

> Then the other guy came in and started saying, well, you decided to be a teacher, you suck it up and continue working. And I was even taking up photography, he said that I was wasting my time, that a photographer was never going to make as much money as a teacher. He told me, why did I marry a Mexican since I knew they were abusive.

Difference in Cultural Background

Participants shared when there was a difference in cultural background, the therapist would not be able to understand where they were coming from. Participants felt that therapists who did not share a similar cultural background could not know about their cultural norms. They felt that the therapist had a difficult time understanding them.

P5 shared,

> I feel like I maybe if it would have been a different background than mine, I could have maybe been a little difficult for them to understand me or would have been a lot more process of probing and questioning to understand a little bit because of the whole feels better that way. Maybe someone from a different background just for not being used to these stereotypes or just constant situations that arise in just a Hispanic family household. They wouldn't understand, they just would see it as

> something that they could try to understand but not really comprehend or speak for.

Cultural Incompetence

When asked to describe their therapist's cultural competence, some participants shared that their therapist did not ask them questions about their culture, even when the participant would discuss their cultural background. Participants felt because their therapist did not ask them questions nor take the time to research about their cultural background and show an interest in them, their cultural identity did not matter. Participants who discussed their cultural background during therapy, felt that if their therapist would have shown an interest and asked questions, it would have made their experience more personalized.

P6 explained,

> He didn't really ask me any questions about like my culture. I felt like that would have helped maybe like slightly. And I feel like they probably would have helped because just to get the understanding of, you know, my background and that like I am a lot, you know, a Latinx person. So, I feel that maybe I would have been more like, you know, more personal in that sense.

Bias of Gender

When there was a difference in gender between the participant and the therapist, participants shared that because their therapist was not the same gender, often they could not relate or understand what they were going through. Participants shared that because the therapist could not relate to their gender-specific issues, they often felt like they were

being judged instead of understood. Because of the different gender of their therapist and the lack of relation, participants did not have a good experience and thus felt misunderstood.

P10 commented,

> I felt like he couldn't understand because he wasn't a female. He didn't really get what I was trying to tell him. I don't feel like he was really understanding or why I was upset or why I was mad. Where my anger came from and all that. And I felt like when I did open up, he was like judging me more than you know taking my side. He was questioning my actions. And I didn't feel comfortable expressing some stuff.

The third theme that emerged from the participants' experiences related to what did not work or the challenges from the therapeutic alliances. Participants shared their experiences in which they felt they did not connect with the therapist based on a difference in age or gender, a different cultural background, or a similar cultural background that is rooted in archaic traditions that do not translate in the 2000s. Participants also shared experiences in which the therapist hindered their progress through words of discouragement or making the participant feel unheard or misunderstood. There was an instance for one participant in which the therapist's cultural incompetence and bias towards her spouse's Latinx ethnicity, caused harm rather than help for the participant. Overall, the things that did not work or were challenges, were similar amongst the ten participants in this study, making outcome negative.

Summary

The purpose of this study was to explore the experiences of self-identifying Latino/a/x who received mental health therapy. The study aimed to explore how self-identifying Latino/a/x former mental health clients perceived the use of language in therapy, the therapists' skills in language and cultural competence, and their overall assessment of the therapeutic experience. The study explored self-identifying Latino/a/x former mental health clients' recommendations regarding mental health therapy.

The first RQ of the study addressed the overall experiences of self-identifying Latino/a/x former clients. From this exploration, participants shared both the positive and not positive experiences they had during their time in therapy. Some of the positive experiences involved their therapist being of the same gender and age, sharing similar cultural background, being able to speak in both Spanish and English, asking them questions about their culture, and providing the participants with skills to help them with the reasons for attending therapy.

The second RQ addressed how cultural variables such as language and ethnicity were perceived by participants during their therapeutic process. Participants shared that when they were able to switch languages, they could share more freely and were more comfortable being able to say things in their native language. Some participants felt that when their therapist had a similar cultural identity, they could relate better. Other participants felt that their therapists of a similar culture had preconceived and antiquated biases about their culture. The therapists who could not switch languages did not necessarily have a negative impact on the outcome of therapy, however, some

participants shared that it would have been better if the therapist could switch languages or at least understand them when they spoke in Spanish.

The third RQ related to how the participants assessed their relationship with their therapist and the overall outcome of therapy. Participants shared both positive and negative relationships that they had with therapists, as many participants had multiple therapists. The participants who had multiple therapists were able to describe what worked well with one and what did not work well with another. The participants who had a favorable outcome of therapy attributed it to similar gender, age, cultural background, switching languages, and being provided with an outlet of support in which to share the challenges they were having at the time. The participants who did not have a positive outcome of therapy attributed it to their therapist not having the same gender and age or a similar culture and having cultural bias.

This Chapter represented the data collection and analysis from a purposive sampling of ten self-identified Latinx people who received mental health therapy treatment within the past three years. In Chapter 5, the limitations of the study, interpretation of the findings, and recommendations for future studies will be presented. The social change implications of this study will also be explored in Chapter 5.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this phenomenological study was to explore the experiences of self-identifying Latino/a/x who received mental health therapy. The secondary purpose of this study was to explore how self-identifying Latino/a/x former mental health clients perceived the use of language in therapy, the therapists' skills in language and cultural competence, and their overall assessment of the therapy experience. Finally, I explored self-identifying Latino/a/x former mental health clients' recommendations regarding mental health therapy. In an extensive literature review, I found a clear gap in research conducted within the past 10 years regarding key components of former clients' experiences, Latino/a/x, mental health therapy, language, and cultural competence.

This study employed an IPA approach (see Charlick et al., 2016; Pietkiewicz & Smith, 2014; Roberts, 2013; Smith et al., 2009) to answer the RQs. IPA was selected for this project given the RQs' implied interest in personal perspective on lived experiences. The participating self-identified Latino/a/x former mental health therapy clients provided details of their lived experiences. The three major themes were attending therapy, positive outcomes/things that worked, and challenges in therapy/things that did not work. These themes came together to represent the core purpose of the study. This Chapter provides an interpretation of the findings and the limitations of the study. Also discussed in this Chapter are the recommendations for future studies and the implications.

Interpretation of the Findings

The results of this study aligned with the literature review findings. Additionally, this study provided new findings regarding a therapeutic alliance between self-identifying Latino/a/x persons and their mental health therapists. Directions for future research and practice can be developed by comparing the findings from this study to previous relatable studies. From the semistructured interviews, data were collected, which revealed three central themes related to the lived experiences of the participants. The three themes that emerged aligned with the findings of previous studies. The literature review conducted in Chapter 2 of this study provided a broad background of the characteristics of therapists who provide therapy to Spanish-speaking clients.

Theme 1: Attending Therapy and Therapist Selection

According to the study results, participants attended therapy and selected therapists for symptoms of depression, anxiety, and stress and to learn life coping skills related to familial relationships. Participants selected their therapists through an online search based on location, whether they provided therapy for their specific reasons, and whether they accepted their insurance. Some participants asked friends for a referral or were appointed a therapist by the court system or military selection. Experiencing depression and insurance coverage are often mentioned as the most significant reasons for attending therapy and selecting a therapist. Fripp and Carlson (2017) found that 53% of the Latino/a/x population experienced moderate to severe depressive symptoms, and this, combined with family issues, were reasons they sought mental health therapy.

According to Derr (2016), participants indicated that insurance was a factor in their use of mental help services to treat diagnosed or self-perceived mental health symptoms. Bridges et al. (2012) found that participants used mental health services for symptoms of depression, domestic violence, and family problems.

Theme 2: Positive Outcome of Therapy/What Worked

Previously, researchers had indicated that when a therapist is culturally competent and speaks the native language of the client, the relationship with the client can either be one of attunement or collusion (Costa & Dewaele, (2012). I frequently found that participants reported a helpful and overall positive experience when the therapist was culturally competent and able to speak their native language of Spanish. However, there were a few instances where the shared or similar culture (the participant used the word similar to describe the cultural background, such as both being from a Caribbean country, or one was Puerto Rican and one was Mexican) between the therapist and the client proved to be a negative experience due to the therapist's preconceived notions and assumptions about the client's cultural background.

Of the monolingual therapists, participants felt most comfortable speaking with those who took an interest in the participant's culture. However, some monolingual therapists did not ask about the cultural background of the participant, and thus, the participants felt like the therapist did not care or did not want to take the time to learn about their cultural norms. Consistent with this finding, Corona et al. (2017) provided a research study involving the Latino/a population attending college in which they discovered there is a significant association between mental health symptoms, cultural

values, and cultural stressors. The cultural norms found to be important for therapists to understand about the Latino/a/x population were *familismo* (the connection and importance of family), traditional gender roles (roles of the male and female within society and their family and community), religiosity (actively involved in their religion), and *respeto* (respect towards elder within their family and community; Corona et al., 2017). Also consistent with the finding regarding cultural norms, Pineros-Leano et al. (2017) found that when therapists used culturally adapted cognitive behavior theory in the treatment of depressive symptoms in the Latino/a/x population, the results appeared promising. From this study, they found that "cultural adaptations help to ensure that (a) the concerns of the participants are addressed, (b) the therapeutic content is consistent with their cultural and linguistic norms and beliefs, and (c) the intervention reflects the client's worldview" (Pineros-Leano et al., 2017, p. 568).

In general, participants reported that the ability to speak in both Spanish and English with their therapist helped to add to their feelings of comfort, understanding, and empathy. Bernal et al. (2009) focused on finding a balance between using the evidence-based treatment and cultural adaptation in which the intervention used by the therapist incorporates the culture and language values of the client. Interiano-Shiverdecker et al. (2021) researched the experiences of Spanish-speaking counselors-in-training who shared that having language and culture knowledge aided in making the client feel more comfortable. Rolland et al. (2017) found that participants who were bi- or multi-lingual clients were more likely to switch languages if they knew the therapist spoke the other language as well.

The participants in this study who liked speaking in English and Spanish also shared that they were prone to do that when they knew their therapist could speak both languages. Those same participants shared that switching languages allowed them to say things in Spanish that did not translate as well in English, which allowed them to express themselves more freely. Santiago-Rivera et al. (2009) found that when the therapists switched from English to Spanish when expressing emotions, their clients were more likely to do the same and thus created the trust and better communication. Walsh's (2014) research on language switching inferred that there are many advantages to providing therapy in more than one language and understanding more than one culture as it can provide a connection to the client. Similarly, Kapasi and Melluish (2015) identified language as an important feature of therapeutic alignment. Moreover, Pérez-Rojas, Brown, Cervantes, Valente, and Pereira (2019) found that the participants in their study preferred being able to express themselves in either Spanish or English when, at times, one language allowed them the opportunity to preserve the meaning of how they were feeling rather than having their words lost in translation by the therapist.

Chang and Yoon (2011) found that therapists should acquire a skill set that will allow them to address REC perceptions in order to have a positive impact on the therapeutic relationship. The participants in this study shared how some therapists took a genuine interest in their REC by asking questions that made the participants feel that the therapists cared about their background and how it affected the issues they were discussing during therapy. One participant shared how their therapist studied in Spain and would speak Spanish with him while at the same time would read up on the client’s

Venezuelan culture and come to their therapy sessions with questions for the client. The participant shared how this made him feel more comfortable in their therapeutic relationship because the therapist took the time after their sessions to learn more about him.

Theme 3: Challenges in Therapy/What Did Not Work

Some participants in this study shared how culture was never asked of them by their therapist, but then it was also not the focus, or their reason, for attending therapy. However, they indicated that if they shared information about the cultural norms within their family and the therapist took interest and acknowledged them, or the therapist did not pursue questioning or interest in how the cultural family norms were affecting the client, it affected the therapeutic relationship. Owen et al. (2011) found that there was a need for therapists to be considerate of their multicultural awareness and their multicultural knowledge in order to relate to their clients' psychological well-being and thus provide a positive working alliance and authentic relationship. Therapists should also take into consideration cultural factors when conceptualizing the clients' issues and providing intervention that best meets the needs of the specific client.

From further previous research, I concur with the findings of this study that the therapist’s lack of bilingual language skills impeded the therapeutic relationship (see Bridges et al., 2012). Fripp and Carlson (2017) suggested that a challenge. Latino/a/x people face when selecting a therapist is finding a therapist who can provide service in both monolingual and bilingual English-Spanish. Additionally, Anderson et al. (2019) found that therapists who have a perceived low (multi)cultural competence contributed to

clients prematurely ending the therapeutic alliance. Maldonado (2021) also identified that Latino/a/x clients were best assisted when the therapists have cultural competence and ask questions to their clients regarding their culture.

Therapists in various studies reported difficulties expressing themselves in Spanish due to a limited vocabulary of psychological concepts in Spanish (Castaño et al., 2007; Sprowls, 2002; Verdinelli & Biever, 2009a, 2009b, 2013). Therapists also reported that their lack of language competency often led to a delay in providing timely responses to their Spanish-speaking clients as they grappled with remembering or finding the correct terminology (Castaño et al., 2007; Estrada et al., 2018; Verdinelli & Biever, 2013). While those studies dealt with the experiences of therapists, the findings are consistent with the findings of this study from the perspective of the self-identifying Latino/a/x former clients. Participants in this study who had therapists who did not speak Spanish found that it would have made their experience better had they been able to express themselves in both English and Spanish. One participant shared that their therapist's ability to speak Spanish was limited by what they knew, and the participant could tell that the therapist was not a native speaker.

Another challenge that participants in this study experienced was the lack of cultural competence of the therapist. Often, they felt that the therapist either did not care or just did not take the time to get to know the participant's cultural ascribed status. In a study on cultural competence, Maldonado (2021) found that when Latinos feel cared about and thus respected, culturally competent therapist is able to gain the trust of their clients. Bhui et al. (2007) found that when therapists showed a genuine interest in

learning about the culture of their clients, rather than treating it as a requirement of their work, the client's experience was positive. This is consistent with my findings that when a therapist does not show a genuine interest in the participant's culture, the outcome of the relationship is not positive.

Conceptual Framework

In this study, I used Santiago-Rivera's (1995) integrative framework in mental health treatment for Latinos. Santiago-Rivera et al. (2009) established a robust case for the inclusion of culture and language in therapeutic services for Spanish-speaking clients. Collins and Arthur (2010) posited that when there is an awareness of the client's cultural background and contextual experiences, the therapeutic alliance develops in a sensitive environment. Santiago-Rivera (1995) stated that assessing clients' level of acculturation, immigration status, language preference, and use, as well as customs, values, and norms, is essential for the development of a client-focused treatment plan. This framework has been used across a wide range of theoretical orientations and therapeutic approaches, and it provided client context. The data from this study were consistent with this concept, as participants frequently reported that when their therapist was aware of, respected, and took an interest in their culture and language, they felt more comfortable.

Limitations of the Study

Limitations of this study included that the original intent was focused on the experiences of a homogenous group labeled as bilingual former clients who received mental health therapy from bilingual therapists; that grouping proved to be too broad to find participants, thus limiting the study participants. The initial recruitment procedure of

asking bilingual therapists to share the study's information with their former clients also proved to be a limitation as none of the over 300 bilingual therapists contacted were willing to take the time to share the study information or did not respond to my contact. The focus of the participants was changed to self-identifying Latino/a/x former mental health clients. At first, seeking participants via social media posts proved to limit the number of respondents. The expansion of recruitment to using Craigslist and paying participants proved to provide the number of participants needed for the study. In fact, I had double the number of participants required for this study who responded to the Craigslist ad, and all of them were enthusiastic about participating. However, a limitation of this new recruitment was being able to afford to pay participants and then trusting that the participants would be honest with their responses not because they were paid but because they wanted to help with the study. Future implications that could help with having more participants share their experiences would be for the researcher to have a grant so that they could pay more participants and, thus, have a slightly larger sampling.

Finally, in Chapter 3, I also discussed how my potential bias and social identity may provide a limitation in the study. I perceived that my experiences as a multilingual person who has lived and studied abroad in Spain and who thoroughly enjoys speaking various languages and learning about other cultures might become a bias due to my passion for the topic of this study. However, through reflexive journaling before, during, and after interviews during data collection, I was able to review any biases I may have felt. Ravitch and Carl (2016) posited that an examination of biases is an ethical

responsibility due to the direct and indirect implications the biases could have on the participants in the study and in the interpretation of the participants' experiences.

Recommendations

The need for more research as it relates to the experiences of self-identifying Latino/a/x former mental health clients is needed so that monolingual and bilingual therapists may improve their therapeutic relationships with these clients. Castaño et al. (2007) and Pro et al. (2022) recognized the large gap in mental health services available to Spanish-speaking clients in their native language as well as the need to provide better training for those who provide mental health services in Spanish. Castaño et al. (2007) also discussed the necessary efforts to educate graduate psychology students in providing bilingual services to their future clients and how training must provide a focus on this so that Spanish-speaking clients' needs are being met. Verdinelli and Biever (2013) found that the Spanish-speaking clients' initial doubts about therapy were relieved when their therapist spoke to them in their native language and shared interest in their cultural values. In reviewing the literature, the clarity of the need to hear from former clients became more apparent because of the saturation of therapists' experiences and viewpoints already being researched. The examples of studies that delved into the therapist's experiences provided the background for the significance of this study and identified the gap in the literature that the clients' experiences should be reviewed and understood to further educate therapists who provide mental health services to the Latino/a/x community.

As previously mentioned, the limitation of not having enough funding to allow for more participants and the recommendation to secure a grant to help with paying participants would provide a more robust compilation of former clients who identify as Latino/a/x. As well, for future research that wants to delve more in-depth into language competence and language switching, being able to pay bilingual former clients may aid in the recruitment of participants. This study could be replicated by changing the ethnicity and or region of the participants to fit with the researcher's purpose of their study. It is known that both cultural competence and language proficiency are key components when providing services to bilingual clients (Castaño et al., 2007; Verdinelli & Biever, 2009a, 2009b; Pro et al., 2022). With a push for introducing a working alliance concept and multicultural counseling competence, there would be a better understanding of the culture-specific inferences that could affect the counselor-client relationship. There is a need for further research as it pertains to the lived experiences of former clients from the Latino/a/x population to investigate how further training of therapists who have clientele from this population could improve their services.

Implications

The positive social change implications for this study will allow for the voices of former clients to be heard, which in turn will provide insight and future study implications for monolingual and bilingual therapists and bilingual mental health facilities to improve the services provided to self-identifying Latino/a/x clients who may speak both Spanish and English. By having a better understanding of the therapeutic experiences of the client who identifies as Latino/a/x and may be bilingual in English and

Spanish, this study can bring about positive social change for both the client and for training programs for monolingual and bilingual therapists.

The themes that resulted from this study and which came from participants' sharing their experiences should be used to improve the ways in which therapists work with self-identifying Latino/a/x clients who prefer, or do not prefer, to speak in both Spanish and English and whose cultural background can affect the outcome of the therapeutic alliance. This study iterates the findings in previous related research in which therapists shared the importance of being culturally competent and or having secondary language skills help to make a more positive experience for the client. As well, those previous studies found that therapists need more education on cultural competency and language skills (Verdinelli & Biever, 2013, 2009a; Biever et al., 2011). This study's findings suggest that the need for more culturally competent and language proficient therapists are essential, and there subsequently needs to be more training available for therapists. The nature of this study utilized IPA given the RQs' implied interest in personal perspective on lived experiences. As the themes related to this study are more thoroughly investigated, in the future, empirical findings should inform structural considerations for all mental health facilities which provide support for self-identifying Latino/a/x persons and or bilingual clientele.

Finally, the conceptual support for this study was determined to be an effective lens to learn about the experiences of self-identifying Latino/a/x former clients who received mental health treatment. An integrative framework for the mental health treatment of Latino/a/x from Santiago-Rivera (1995) and Collins and Arthur (2010)

established a robust case for the inclusion of culture and language in therapeutic services for Spanish-speaking clients. Collins and Arthur (2010) posit that when there is an awareness of the client's cultural background and contextual experiences, the therapeutic alliance develops in a sensitive environment. Given the successful application, these orientations might effectively be applied in future studies and in practical training for mental health therapists who work with the Latino/a/x population and or other cultural/language backgrounds.

Conclusion

The purpose of this phenomenological study was to explore the experiences of self-identifying Latino/a/x who received mental health therapy with either a monolingual or bilingual therapist. The study explored how self-identifying Latino/a/x former mental health clients perceived the use of language in therapy, the therapists' skills in language and cultural competence, and their overall assessment of the therapeutic experience. The study also explored self-identifying Latino/a/x former mental health clients' recommendations for therapists regarding mental health therapy treatments. Having the opportunity to speak on their experiences, self-identifying Latino/a/x former clients explained the importance of therapists being culturally competent or asking questions to allow for understanding, as well as being able to listen and or speak to them in another language when they felt more comfortable switching language. By sharing their lived experiences from their therapeutic sessions, the participants in this study demonstrated their desire to improve alliances between Latino/a/x clients and their therapists while also providing insight into what worked well for them. Through improved therapist training

within the realm of cultural competency and foreign language skills, Latino/a/x clientele can reap the benefits of having mental health treatment that fits their needs. As one of the participants of this study succinctly noted, "She allowed me to express myself in whichever language I felt comfortable with and preferred, and in whichever language, I felt like she could best understand me. And she definitely did. So, I think it did help."

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Appendix: Interview Guide

RESEARCH QUESTIONS
AND
INTERVIEW QUESTIONS

Background questions:

1. What is your age?
2. Tell me about yourself and your family. For example, marital status, children in household, ages of everyone in the household, where you originate from.
3. From what type of licensed therapist did you seek therapy? For example, psychologist, social worker, LCPS.
4. Do you know if the bilingual therapist you met with was a native speaker?
5. How long did you seek mental health treatment?
6. How long has it been since you were seeing the therapist?
7. In general terms, what was the main reason for seeking therapy?

RESEARCH QUESTION 1

RQ1. What are self-identifying Latino/a/x former mental health therapy clients' experiences in therapy?

INTERVIEW QUESTIONS FOR RQ1:

a. Describe to me how you found the therapist with whom you met.
b. What were the reasons why you selected that therapist?
c. What were your expectations of therapy with a mental health therapist?
d. Describe to me how you felt after your sessions with the therapist.

e. Do you feel that therapy with a therapist improved your experience or made no difference at all and why?

RESEARCH QUESTION 2

RQ2. How do self-identifying Latino/a/x former mental health therapy clients perceive cultural variables such as language and ethnicity in the therapeutic process?

INTERVIEW QUESTIONS FOR RQ2:

a. What were your initial impressions of the therapist's language skills? Cultural competence – did the therapist have a general understanding of your culture? Did the therapist want to know more about your culture by asking questions to you? Did the therapist take the time to get to know cultural norms within your own family?

b. Based on your impressions of the therapist's language skills and cultural competence, do you feel those variables helped or hurt your therapeutic experience?

RESEARCH QUESTION 3

RQ3. How do self-identifying Latino/a/x former mental health therapy clients assess their relationship with their therapist and the overall outcome of therapy?

INTERVIEW QUESTIONS FOR RQ3:

a. What was the outcome of your therapy?

b. Do you feel the relationship with your therapist affected the outcome of your therapy?
