Check for updates

Original Article

The International Journal of Bilingualism

International Journal of Bilingualism
1–12
© The Author(s) 2020
Article reuse guidelines:
sagepub.com/journals-permissions
DOI: 10.1177/1367006920902522
journals.sagepub.com/home/ijb

Beyond basic communication: The role of the mother tongue in cognitive-behavioral therapy (CBT)

Michal Tannenbaum and Eden Har
School of Education, Tel Aviv University, Israel

Abstract
Immigration is a crisis-prone, complex process, often involving the need to acquire a new language, frequently at the expense of the mother tongue. Thus, the phenomenon of immigrants requiring various forms of mental health assistance while having limited fluency in the therapist's language is widespread. Cognitive behavioral therapy (CBT) has become a widely prevalent therapeutic approach in many countries, including countries absorbing immigrants. This article reviews case studies that relate to the use of CBT with immigrants, both in individual and group sessions, focusing on the position of *the patient's mother tongue* in the process. Research has persistently shown that the mother tongue is emotionally significant—using it, being exposed to it, expressing emotions and understanding emotions expressed in it, having access to it and to memories encoded in it, and the like. Given these dimensions, it plays a potentially important role in the therapeutic process. The pivotal question, then, is whether a therapeutic process that is essentially emotional can be effective if the mother tongue is not an inherent part of it. This article addresses this issue while examining the mother tongue's position in CBT, the therapists' awareness of these issues, the accommodations, if any, made in this regard, the therapists' point of view, and suggestions for improving the use of CBT with immigrants. It is written to be of relevance to a diverse audience including researchers from varied disciplinary backgrounds, therapists who work with multilingual patients (especially immigrants or members of other minority groups) or are multilingual themselves. Our aims, therefore, are to contribute to the theoretical understanding of the mother tongue's centrality in emotional processes and to offer some practical recommendations for therapists and training institutions.

Keywords
Cognitive behavioral therapy (CBT), immigration, mother tongue, emotions, trauma

Introduction

Immigration is a crisis-prone, complex process entailing personal, familial, professional, and other challenges and difficulties. Often, it also involves a need to acquire a new language, frequently at the expense of the mother tongue. Thus, the phenomenon of immigrants requiring various forms of

Corresponding author:
Michal Tannenbaum, School of Education, Tel Aviv University, Ramat Aviv, Tel Aviv, 69978, Israel.
Email: mtannen@post.tau.ac.il

mental health assistance while having limited fluency in the therapist's language (usually the language of the new society) is widespread.

Worldwide immigration rates are currently extremely high and on the rise (OECD/ILO/IOM/UNHCR, 2018). Many of these immigrants are fleeing wars, persecution, and challenging economic conditions, and often undertake harsh journeys in circumstances involving hunger and violence (OECD/ILO/IOM/UNHCR, 2018). Both prior to their migration and during their journey, then, they undergo traumatic experiences that could lead them to seek mental health assistance following their arrival in the new society.

Cognitive behavioral therapy (CBT) has become a widely prevalent therapeutic approach in many countries, including countries absorbing immigrants. CBT owes its popularity to characteristics such as being evidence-based (unlike, for example, psychoanalysis), applicable to a wide range of emotional difficulties, and short-term (Butler et al., 2006; Hofmann & Smits, 2008). It is often the choice in intervention programs with immigrants, asylum seekers, and refugees in many places, both in government community programs and in private clinics.

This article reviews case studies that relate to the use of CBT with immigrants, both in individual and group sessions, focusing on the position of *the patient's mother tongue* in the process. Research has persistently shown that the mother tongue is emotionally significant—using it, being exposed to it, expressing emotions and understanding emotions expressed in it, having access to it and to memories encoded in it, and the like (Dewaele, 2008, 2010; Dewaele & Nakano, 2013; Pavlenko, 2006; Tannenbaum, 2012). Given these dimensions, it plays a potentially important role in the therapeutic process, as discussed below. The pivotal question, then, is whether a therapeutic process that is essentially emotional can be effective if the mother tongue is not an inherent part of it. This article addresses this issue while examining the mother tongue's position in CBT, the therapists' awareness of these issues, the accommodations, if any, made in this regard, the therapists' point of view, and suggestions for improving the use of CBT with immigrants.

This paper is written to be of relevance to a diverse audience including researchers from varied disciplinary backgrounds, therapists who work with multilingual patients (especially immigrants or members of other minority groups) or are multilingual themselves. Our goals, therefore, are to review the field, identify a need, and call for research on it. We aim to contribute to the theoretical understanding of the mother tongue's centrality in emotional processes and to offer some practical recommendations for therapists and training institutions.

What is cognitive behavioral therapy?

CBT is a therapeutic method addressing the mutual associations between thought, emotions, and behavior (Beck, 2019). It is a target-focused therapy, explicit, directed at change, and evidence-based. The therapeutic model emphasizes that emotions evolve from basic beliefs, interpretations, and reactions to everyday life events. Thus, patients learn skills and tools to identify irrational, maladaptive beliefs and thought distortions that are sometimes experienced as undisputed truth and often prove destructive. Patients learn to identify such thoughts and gradually replace them with rational ones. Consequently, they also change their behavior and their reactions to life events, regulating their emotions accordingly.

CBT uses various "technical" intervention tools such as monitoring, identifying thought distortions, psycho-educational explanations, writing up tables, and suggestions for alternative rational thoughts. These interventions expand the thinking interpretive processes to more realistic perceptions, which view the world as less of a threatening, dark, and humiliating place, while also regulating the emotional intensity (Beck, 1976). Most of these techniques have a fixed structure. The first stage is assessing the patient's state according to their own reports. If the patient presents a known

diagnosis according to the *Diagnostic and Statistical Manual of Mental Disorders* (DSM–5; American Psychiatric Association, 2013) or *International Classification of Diseases* (ICD-11; World Health Organization, 2018), the therapist will use the relevant protocol. The therapist will go beyond the diagnostic label, however, to conceptualize the patient's unique case in light of his/her background and history. The beginning of the treatment serves as a baseline for measuring the effectiveness of the process in the middle and at the end. The next phase is usually the psycho-educational one. Patients are then presented with their reported problem, usually in a visual manner, based on psychological theories, previous research-related findings, and on what the therapist thinks is the optimal way of dealing with these difficulties. This phase is supposed to raise the motivation for therapy, make the difficulties be perceived as more familiar and "normal," and involve the patient in the process (Beck, 2019).

Another phase, essential in CBT, is self-monitoring, which serves both assessment and therapy. Self-monitoring enables patients to gain awareness of patterns in the links between their emotions–feelings–behaviors–thoughts, to be exposed to them despite the difficulties this entails, and to draw away from them to be more aware of them and of their rationality. Thus, for example, during this phase the patient identifies an event that triggered the problem, writes down thoughts that emerged in this context, how much he believes in each one of these thoughts on a scale from 1–10, what emotions it awakened and their intensity on a scale from 1–10, and what thought distortions characterize these thoughts, behaviors, and alternative thoughts (Beck, 1976).

The therapeutic relationship in CBT is based on cooperation between the therapist and the patient, who work together to achieve a declared goal. Patients are encouraged to raise emotional experiences or behavioral responses in the clinic revealing thoughts, beliefs, and physiological reactions that can be examined and evaluated as a response pattern to triggers. In this kind of therapy, patients become active figures, partners in data collection and practicing through "homework" between sessions, containing and organizing information related to their difficulties. Homework is an essential part of CBT and, in its course, patients practice the techniques they learned during therapy between sessions. It is explained to patients that the more they practice these techniques, the more efficient the therapy will be and the longer the effects of its outcomes, as research results indeed show (see, e.g. Kazantis et al., 2005).[1] Patients are often advised to purchase a self-help book according to the specific aim of the treatment, which will accompany the sessions (Sharf, 2015).

Compared with other therapeutic approaches (certainly psychodynamic ones), CBT is less focused on the etiology of the psychopathology and more on ways of actualizing cognitive-behavioral-emotional-physiological change. The intent of most interventions, therefore, is to change these processes and the preserving behaviors at the basis of the psychopathology. All CBT theories share the perception that all psychopathologies have one common denominator: dysfunctional associations between behavior, thought, and emotion, which are sustained and strengthened by avoidance behavior as well as affected by cognitive mechanisms such as attention and memory (Beck, 2019).

The mother tongue and emotional loading

Studies of bi/multilingualism (including personal memoirs, subjective ratings, and electrodermal response lab studies) repeatedly report that greater emotionality is embedded in the first language (L1) compared with later-acquired and -learned languages (in adolescence or later). These differences in emotional loading are especially evident in regard to taboo words, swearwords, expressions of love, and even advertising slogans, and are especially meaningful in the context of intimate interactions such as those with a spouse or in family contexts when interlocutors do not share the

same L1 (Caldwell-Harris et al., 2010; Dewaele, 2008, 2010; Dewaele & Nakano, 2013; Harris, 2004; Pavlenko, 2004, 2006; Tannenbaum, 2012). No less important is the finding that people who acquired a language at a later age find it relatively more difficult to *identify* feelings expressed in this language by comparison with its native speakers (e.g. Rintell, 1984). Studies have also pointed out that bi/multilinguals tend to present themselves differently in their different languages, both in terms of narratives in these languages (Koven, 2001; Marian & Kaushanskaya, 2004), and in terms of personality profiles (e.g. Chen & Bond, 2010; Dewaele & Stavans, 2014; Hull, 1996; Panicacci & Dewaele, 2017).

Extensive discussion of this topic in the research literature yielded several explanations. Of particular interest here is the psychological perspective, addressing issues of identity and intimate relationships as related to language. Thus, the mother tongue is seen as the language of attachment and early significant intimate relationships and, as such, part of basic, early developmental experiences. A different language could thus be associated with different experiences of self and other (Amati-Mehler et al., 1993; Foster, 1992). Harris et al. (2006) suggest that a first language is more emotional since it is universally learned in a highly emotional context—the one of attachment to caregivers—while languages learned at later stages vary in the emotionality of their context. Recognizing the emotional intimacy inherent in adult–infant interactions, Zeedyk (2006) argues that individualistic capacities such as self-awareness, representation, and consciousness can only arise through intimate engagement with others. During adolescence and in later years, however, the self is relatively more structured and independent. Significant others are already internalized and close intimate relations develop on the basis of those early ones (Bowlby, 1977, 1988; Sroufe, 2000; Winnicott, 1990). Taken together, these findings and ideas clearly point to the significant emotional role of the first language in terms of self-construction, identity, intrapsychic dynamics, and intimate relationships.

Language and emotions in therapy

Given the extensive discussion about the centrality of language in emotional contexts, about the meaning of contact with the mother tongue insofar as memory, emotional description, and emotional understanding are concerned, all are obviously highly relevant in the therapeutic context as well. When psychotherapy takes place in a language that the patient acquired later in life, after early childhood,[2] it is likely that the emotional communication will be different (indeed, somewhat dimmed) compared with psychotherapy in one's first language. Many case studies in the psychological literature illustrate this claim, showing how the *new* language is sometimes a tool used to avoid painful emotions and/or traumatic memories, when the patient, consciously or unconsciously, chooses a distancing language.

Often, reporting stressful events in the new language decreases anxiety in what is termed a "detachment effect" (Bamford, 1991; Marcos, 1976), in line with many studies pointing to higher emotional loading when describing emotional experiences (Koven, 2001) or making rational decisions in the first language (Keysar et al., 2012). The therapeutic process involves subtle considerations on the role of language that are linked, inter alia, to language shifts or code-switching (Amati-Mehler et al., 1993; Bollas, 1987; Foster, 1992, 2001; Javier, 1995; Marcos, 1976).

Related to this context are the interesting studies of Foa and her colleagues on PTSD and anxiety disorders suggesting that, in these disorders, "fear networks" that are constructed in the long-term memory tend to consolidate when there is avoidance and emotional denial (e.g. Brown et al., 2019; Foa, 1993; Foa & Kozak, 1986; Foa et al., 1992). Consequently, Foa (Foa, 1993; Foa & Kozak, 1986; Foa et al., 1992) suggested that the optimal therapy for trauma is to integrate the information of fear networks (coded in certain aspects of language) with existing memory structures. The therapist, therefore, must show a therapeutic flexibility that merges the mother tongue with the new language.

Nevertheless, the patient often has no choice as to the language of the therapeutic interaction, all the more so when it involves immigrants and ethnolinguistic minorities speaking languages that are less common in the new society. Given the centrality of the first (and/or dominant) language, awareness is required of the potential implications for the effectiveness of therapy when it cannot be conducted in that language.

CBT therapists using the patient's mother tongue

The community of therapists, including CBT practitioners, appears to be insufficiently aware of the therapeutic significance of the patient's language. When therapeutic responsibility is discussed in language contexts, the issue addressed is usually the patient's ability to understand the therapist, possible cultural interpretations, and the overall approach to therapy. By and large, however, there is no explicit reference to the therapeutic significance of the mother tongue (see e.g. Gladding, 2003)

Use of the mother tongue is only partially mentioned in the therapists' ethic rules but, as noted, without alluding to its therapeutic significance. Thus, according to the ethical rules of the American Psychological Association (2017), except for a request to show sensitivity to the patient's cultural background, there is no clear reference to psychologists treating patients from cultural-linguistic minorities

> Psychologists are aware of and respect cultural, individual, and role differences, including those based on age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socioeconomic status, and consider these factors when working with members of such groups. (Principle E, p. 4)

Similarly, the ethical code of the American Counseling Association (ACA, 2014), addresses the language difficulties experienced by patients during therapy and states that counselors should use a clear language:

> Counselors communicate information in ways that are both developmentally and culturally appropriate. Counselors use clear and understandable language when discussing issues related to informed consent. When clients have difficulty understanding the language that counselors use, counselors provide necessary services (e.g. arranging for a qualified interpreter or translator) to ensure comprehension by clients. (Standard A.2.c, p. 4)

If the patient has difficulties understanding the language, the counselor must enable interpretation services to ensure comprehension (Sue & Sue, 2019). This approach to the clarity of language is indeed necessary to transfer information to the patient but does not reflect therapeutic understanding of the mother tongue's deep emotional meaning. Moreover, although this suggestion reflects good intentions, using interpreters could be detrimental to the therapy's effectiveness because it is indirect, hampers intimacy, and might give rise to issues interfering with the treatment. Indeed, many therapists decide to give up on interpreters claiming that the therapeutic relationship and the patient's confidentiality might be affected (Alexander et al., 2004; Gerrish et al., 2004). Patients also reported concerns about privacy violation, especially when the interpreter belongs to the same community. In addition, differences in accent or in dialects between the patient and the interpreter were also reported by patients as affecting communication (Marshall et al., 1998; Tribe & Lane, 2009; Tribe & Sanders, 2003), as well as reports stating that class gaps or different value systems affected the therapeutic relationship (Bayes & Neill, 1978).

Some CBT programs address the issue more explicitly. For example, a CBT program in Spanish, *Vida Alegre*, was initiated in the USA aiming to serve a wide Hispanic public in their mother tongue. Cintrón et al. (2018) elaborate on the advantages of this program, showing how the use of the patient's mother tongue increases motivation for therapy and lowers dropout rates. The problems confronting therapists included difficulty translating the patient's Spanish into professional therapeutic terms. Thus, although the therapists are bilingual, they frequently had trouble finding the precise professional terms because most of their training had been in English. In addition, therapists reported that switching between languages is often exhausting (see also Engstrom & Min, 2004; Engstrom et al., 2009). Cultural-adjusted CBT (CA-CBT) deals mainly with PTSD and associated symptoms such as somatization, anxiety, and anger. Its focus is on emotional regulation techniques and emotional exposure such as meditation and other methods of the third wave.[3] This protocol has been tested with refugees from Cambodia, Vietnam, and Hispanic minorities in the USA (Hinton et al., 2005, 2009, 2011). A study of Iranian refugees in Germany diagnosed with PTSD (Kananian, et al., 2017) used a CA-CBT protocol. In this therapy group, the therapists were bilingual Persian-German and shifted between the languages in accordance with developments in the group dynamics, the contents raised, and so forth. Rates of dropouts were low, probably due to the fact that a support group was created where participants understood one another. The fact that patients and therapists shared a similar background and the same mother tongue was an additional factor in the high motivation to stay in therapy, which helped to bridge gaps when grappling with difficult emotional issues. Possibly, the therapist may also have served as a successful model of integration into German society. Findings pointed to lower rates of anxiety, depression, and sleeping difficulties.

Another example of cultural and language adaptation is a government project with Hispanic immigrants in the USA, which offered Spanish-translated CBT protocols free of charge (Muñoz & Miranda, 2000) and was found to be effective. A meta-analysis that analyzed the results of eleven different studies on the effectiveness of CBT use with Hispanic immigrants, showed that all of them reported changes made in the course of the therapy in order to simplify and ease access to the language used in the therapeutic intervention by involving bilingual moderators who could sometimes translate the therapeutic content to the patients.

In all these examples, however, no explicit reference was made to the crucial role of the patient's mother tongue in the therapeutic process, neither in the sessions nor in the homework. Generally, these therapeutic courses of treatment reported only partial success (Cintrón, et al., 2018).

Partial treatment in the mother tongue; when therapist and patient do not share a language

Patients who belong to ethnolinguistic minorities may find it hard to share their thoughts and beliefs with their therapists in a language that is not their mother tongue—their proficiency may be limited or things may get lost in translation, making the cognitive work less efficient.

Weiss et al. (2011) reviewed two case studies focusing on social anxiety disorder. In one case, the therapist recommended that homework be carried out in Spanish, the patient's mother tongue, even though he himself did not speak it. The patient reported this arrangement had proved extremely efficient because his thoughts were thereby better connected with, and more strongly influenced by, his emotions, as the therapist's report corroborated. The other case study involved a patient of Chinese origin who also did her homework in her mother tongue and also reported she had found it easier since this was the language in which she experienced her thoughts. She also reported it had

been easier for her to recognize her thought distortions and basic beliefs in her mother tongue, in turn improving the efficiency of the therapeutic process.

Another relevant project studied eleven bilingual welfare workers of Somali origin working in Minneapolis (Pratt et al., 2017). They were trained to supervise CBT group meetings with war refugees of Somali origin. In total, there were 55 female participants whose mother tongue was Somali, contending with difficulties related to their immigration. Overall, the therapy resulted in decreased anxiety levels and higher levels of happiness. Most participants were positive about the intervention, mainly, they claimed, because it was conducted by a member of their community. They reported acquiring problem-solving skills, lower stress levels, anger management techniques, and the adoption of a new approach to the stigma of mental difficulties. Yet, they also mentioned they could have benefited more had the use of Somali been more accurate.

CBT with no mother tongue involvement

Therapy in the mother tongue requires available therapists who speak the patient's language, at times a minority language with a limited number of speakers. They also have to be trained in CBT, be accessible to patients, and, above all, understand the significance of the mother tongue in the therapeutic process. This is a complex combination of factors and, as noted, CBT for members of minority groups is usually not offered to them in their languages.

Bernardes (2011) describes a case study of an Iranian immigrant living in England who was diagnosed with PTSD after he was attacked in his restaurant. He underwent CBT in English and, as part of his homework, was asked to describe (in English) the traumatic experience. Success was partial: his general health improved but not the trauma-related stress symptoms. The homework in English intended to "reawaken the trauma" was less effective. Note that he experienced the trauma in English (in the sense that this was the language in the event's surroundings) but he probably encoded the emotional experience in his mother tongue – the language of self-speech.

Cohen et al. (2012), who wrote a book about trauma-focused CBT, suggest that, when dealing with bilingual children, therapists should take into account the language in which the trauma manifests. Approaching the narrative in the language it was encoded is crucial and, before treating trauma patients, decisions should be reached as to the language that the child and her or his parents wish to use in the therapy.

Conclusions

The role of the language used in CBT (mother tongue vs. later-acquired languages) is in need of further study. The mother tongue encompasses large reservoirs of emotional information and when therapy uses a language acquired at later stages of life, it risks losing knowledge vital to the treatment's success. To conduct CBT under optimal conditions, the therapist must also have access to primal feelings, to early memories as encoded, and to basic beliefs and (distorted) thoughts, often formulated in the first language.

This article examined the importance of using the mother tongue in CBT with bi/multilingual immigrant patients. The studies reviewed showed the partial success of treatment conducted in the new language, showing with some improvement in anxiety and stress levels but not in more complex mental diagnoses such as PTSD.

Furthermore, the studies did not generally address the language used in the therapy as a possible reason for the partial success and ascribed it mainly to the patients' socio-cultural difficulties and to cultural gaps. Though these variables are certainly important, our recommendation here is that future studies should explicitly focus on the language angle, paying attention to non-use of the

mother tongue as a key element that could affect CBT outcomes rather than as a secondary or indirect variable. Several studies explicitly adopting this approach showed evidence of therapeutic success, with patients themselves describing the experience as allowing them to identify their thought distortions and basic beliefs more effectively and more naturally, as well as affording them better access to their emotions and to their "re-living."

More systematic research on the influence of using the mother tongue on the effectiveness of CBT with immigrants will contribute both to the theoretical understanding of links between language, emotional aspects, and mental health, as well as to practical recommendations for CBT. These questions could be addressed in studies comparing CBT using only the patient's mother tongue, partial use of the mother tongue, and use of the new language alone. This type of research will enable improvement of protocols that strive to adapt to the immigrant population, such as CA-CBT, and help to improve training programs for CBT practitioners working with immigrants.

Therapists who can offer treatment in several languages are obviously increasingly needed in multilingual and multicultural societies, yet their availability is limited. Nevertheless, and even if they are not fluent in minority languages, therapists should be aware of the importance of the mother tongue for optimizing CBT results. Thus, given that CBT is a structured process involving defined elements (monitoring, psycho-educational explanations, homework, skills, tools), it could be suggested that, in areas related to raising emotional topics from memory, including homework and monitoring, patients could use their mother tongue and translate these contents for the therapist during sessions. Moreover, attempts to raise emotions to consciousness and relive them in the therapy through techniques like guided imagery could prove ineffective when discussed in the acquired language, and should perhaps be replaced with techniques that require writing in the native language and translating for the therapist. This approach would allow access to more primal emotions and a kind of self-therapy combined with the therapist's supervision.

CBT self-help books containing many assessment and treatment tools that patients can make use of on their own are often recommended for treatment. If patients are referred to such books in their mother tongue (assuming they know how to read in it), the therapist and the patient will have a shared source of reference during the treatment that will enable the therapist to structure the therapy framework, and help the patient use the tools offered in the book in more effective ways. Regarding these suggestions, future research focusing on their use and effectiveness will enable understanding of the more "vulnerable" features of CBT in terms of language use, and what aspects of the process should preferably be conducted in the mother tongue.

Given that language is intertwined with our cognition and our behavior in so many ways and at so many layers, it is only natural to give it a central place in CBT, a therapeutic approach focusing on the meeting points between them. If that is indeed the case, the mother tongue should be assigned a key role and therapists should be aware of its centrality in internal-emotional processes and, consequently, in cognitive-behavioral ones as well. Institutions that train CBT therapists must add an explicit cultural and language reference to bi/multilingual patients and develop advanced courses for practitioners addressing ways of working with patients whose mother tongue is not the dominant language. Beyond technical aspects and concrete solutions, therapists should deepen their understanding of the mother tongue's emotional significance and of the potential implications of its use vs. that of later-acquired languages.

Declaration of conflicting interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) received no financial support for the research, authorship, and/or publication of this article.

ORCID iD

Michal Tannenbaum https://orcid.org/0000-0002-9033-9475

Notes

1. Many studies demonstrate the effectiveness of the method in various psychopathologies, including obsessive-compulsive disorder, anxieties, depression, personality disorders, trauma, eating disorders, and so forth (e.g. Hofmann & Smits, 2008; Hofmann et al., 2012).
2. There is no clear-cut age on this matter. Yet, it is a robust finding that languages acquired after the years of early childhood and around adolescence (in itself a fuzzy concept), evoke lower emotional responses compared with reactions and feeling of authenticity in one's first language.
3. The first two generations of CBT are characterized by the assumption that specific cognitions, emotions, and physiological states lead to dysfunctional and maladaptive behavior, and therapeutic interventions are aimed at reducing these problems. The "third wave" of CBT, dating to about 2004, reflects a change in orienting assumptions within CBT and new behavioral and cognitive approaches focusing more on the person's relationship to thought and emotion than on their contents. Third wave methods emphasize such issues as mindfulness, emotions, acceptance, values, goals, and meta-cognition. New models and intervention approaches include acceptance and commitment therapy, dialectical behavior therapy, mindfulness-based cognitive therapy, functional analytic psychotherapy, meta-cognitive therapy, and several others (see e.g. Hayes, 2004; Hayes & Hofmann, 2017).

References

Alexander, C., Edwards, R., & Temple, B. (2004). Psychotherapy of PTSD in cooperation with interpreters. *Verrhalensterapie*, *9*, 211–220.

Amati-Mehler, J., Argentieri, S., & Canestri, J. (1993). *The Babel of the unconscious: Mother tongue and foreign languages in the psychoanalytic dimension*. (J. Whitelaw-Cucco, Trans.). International University Press (Original work published 1990).

American Counseling Association. (2014). *ACA code of ethics*. Author.

American Psychiatric Association. (2013). *Diagnostic and Statistical Manual of Mental Disorders (DSM)* (5th Edition). Arlington, VA: APA.

American Psychological Association. (2017). *Ethical principles of psychologists and code of conduct*. Author.

Bamford, K. W. (1991). Bilingual issues in mental health assessment and treatment. *Hispanic Journal of Behavioral Sciences*, *13*(4), 377–390.

Bayes, M., & Neill, K. T. (1978). Problems for paraprofessionals in mental health services. *Administration in Mental Health*, *6*, 133–146.

Beck, A. T. (1976). *Cognitive therapy and the emotional disorders*. International Universities Press.

Beck, J. S. (2019). *Cognitive behavior therapy: Basics and beyond* (2nd Edition). Guilford Publications.

Bernardes, D. (2011). Learning from an Iranian man about CBT for treatment of PTSD. *Ethnicity and Inequalities in Health and Social Care*, *4*(4), 210–216.

Bollas, C. (1987). *The shadow of the object: Psychoanalysis of the unthought known*. Columbia University Press.

Bowlby, J. (1977). The making and breaking of affectional bonds. *The British Journal of Psychiatry*, *130*, 201–210.

Bowlby, J. (1988). From: *A secure base: Clinical applications of attachment theory*. Chapter 2: The origins of attachment theory (pp. 20–38). Routledge.

Brown, L. A., Zandberg, L. J., & Foa, E. B. (2019). Mechanisms of change in prolonged exposure therapy for PTSD: Implications for clinical practice. *Journal of Psychotherapy Integration*, *29*(1), 6–14.

Butler, A. C., Chapman, J. E., Forman, E. M., & Beck, A. T. (2006). The empirical status of cognitive-behavioral therapy: A review of meta-analyses. *Clinical Psychology Review*, *26*(1), 17–31.
Caldwell-Harris, C. L., Tong, J., Lung, W., & Poo, S. (2010). Physiological reactivity to emotional phrases in Mandarin–English bilinguals. *International Journal of Bilingualism*, *15*(3), 329–352.
Chen, S. X., & Bond, M. H. (2010). Two languages, two personalities? Examining language effects on the expression of personality in a bilingual context. *Personality and Social Psychology Bulletin*, *36*(11), 1514–1528.
Cintrón, V., Piedra, L. M., & Pineros-Leano, M. (2018). Vida alegre: Teaching cognitive behavioral therapy in Spanish. *Journal of Teaching in Social Work*, *38*(3), 292–310.
Cohen, J. A., Mannarino, A. P., & Deblinger, E. (2012). *Trauma-Focused CBT for children and adolescents: Treatment applications*. Guilford Press.
Dewaele, J.-M. (2008). The emotional weight of I love you in multilinguals' languages. *Journal of Pragmatics*, *40*(10), 1753–1780.
Dewaele, J.-M. (2010). Multilingualism and affordance: Variation in self-perceived communicative competence and communicative anxiety in French L1, L2, L3 and L4. *International Review of Applied Linguistics in Language Teaching*, *48*(2–3), 105–129.
Dewaele, J.-M., & Nakano, S. (2013). Multilinguals' perceptions of feeling different when switching languages. *Journal of Multilingual and Multicultural Development*, *34*(2), 107–120.
Dewaele, J.-M., & Stavans, A. (2014). The effect of immigration, acculturation and multicompetence on personality profiles of Israeli multilinguals. *International Journal of Bilingualism*, *18*(3), 203–221.
Engstrom, D. W., & Min, J. W. (2004). "You just have to do a lot more for them": Perspective of bilingual social workers. *Journal of Ethnic and Cultural Diversity in Social Work*, *13*(2), 59–82.
Engstrom, D. W., Min, J. W., & Gamble, L. (2009). The field practicum experiences of bilingual social work students. *Journal of Social Work Education*, *45*(2), 209–224.
Foa, E. B. (1993). Posttraumatic stress disorder in rape victims. *Review of Psychiatry*, *12*, 273–303.
Foa, E. B., & Kozak, M. J. (1986). Emotional processing of fear: Exposure to correct information. *Psychological Bulletin*, *99*(1), 20–35.
Foa, E. B., Zinbarg, R., & Rothbaum, B. O. (1992). Uncontrollability and unpredictability in post-traumatic stress disorder: An animal model. *Psychological Bulletin*, *112*(2), 218–238.
Foster, R. P. (1992). Psychoanalysis and the bilingual patient: Some observations on the influence of language choice on the transference. *Psychoanalytic Psychology*, *9*(1), 61–76.
Foster, R. P. (2001). When immigration is trauma: Guidelines for the individual and family clinician. *American Journal of Orthopsychiatry*, *71*(2), 153–170.
Gerrish, K., Chau, R., Sobowale, A., & Birks, E. (2004). Bridging the language barrier: The use of interpreters in primary care nursing. *Health & Social Care in the Community*, *12*(5), 407–413.
Gladding, S. (2003). *Group work. A counseling specialty*. Merrill Prentice Hall.
Harris, C. L. (2004). Bilingual speakers in the lab: Psychophysiological measures of emotional reactivity. *Journal of Multilingual and Multicultural Development*, *25*(2–3), 223–247.
Harris, C. L., Gleason, J. B., & Ayçiçegi, A. (2006). When is a first language more emotional? Psychophysiological evidence from bilingual speakers. In A. Pavlenko (Ed.), *Bilingual minds: Emotional experience, expression and representation* (pp. 257–283). Multilingual Matters.
Hayes, S. C. (2004). Acceptance and commitment therapy, relational frame theory, and the third wave of behavioral and cognitive therapies. *Behavior therapy*, *35*(4), 639–665.
Hayes, S. C., & Hofmann, S. G. (2017). The third wave of cognitive behavioral therapy and the rise of process-based care. *World Psychiatry*, *16*(3), 245–246.
Hinton, D. E., Chhean, D., Pich, V., Safren, S. A., Hofmann, S. G., & Pollack, M. H. (2005). A randomized controlled trial of cognitive-behavior therapy for Cambodian refugees with treatment-resistant PTSD and panic attacks: A cross-over design. *Journal of Traumatic Stress*, *18*(6), 617–629.
Hinton, D. E., Hofmann, S. G., Pollack, M. H., & Otto, M. W. (2009). Mechanisms of efficacy of CBT for Cambodian refugees with PTSD: Improvement in emotion regulation and orthostatic blood pressure response. *CNS Neuroscience and Therapeutics*, *15*(3), 255–263.

Hinton, D. E., Hofmann, S., Rivera, G., Otto, E., Pollack, M. W., & Mark, H. (2011). Culturally adapted CBT (CACBT) for Latino women with treatment-resistant PTSD. A pilot study comparing CA-CBT to applied muscle relaxation. *Behaviour Research and Therapy*, *49*(4), 275–280.

Hofmann, S. G., Asnaani, A., Vonk, I. J., Sawyer, A. T., & Fang, A. (2012). The efficacy of cognitive behavioral therapy: A review of meta-analyses. *Cognitive Therapy and Research*, *36*(5), 427–440.

Hofmann, S. G., & Smits, J. A. J. (2008). Cognitive-Behavioural Therapy for adult anxiety disorders: A Meta-analysis of randomised placebo controlled trials. *Journal of Clinical Psychiatry*, *69*(4), 621–632.

Hull, P. V. (1996). Bilingualism: Some personality and cultural issues. In D. I. Slobin, J. Gerhardt, A. Kyratzis, & J. Guo (Eds.), *Social interaction, social context, and language: Essays in honor of Susan Ervin-Tripp* (pp. 419–434). Lawrence Erlbaum.

World Health Organization. (2018). International classification of diseases for mortality and morbidity statistics (11th Revision). Retrieved from https://icd.who.int/browse11/l-m/en

Javier, R. A. (1995). Vicissitudes of autobiographical memories in a bilingual analysis. *Psychoanalytic Psychology*, *72*(3), 429–438.

Kananian, S., Ayoughi, S., Farugie, A., Hinton, D., & Stangier, U. (2017). Transdiagnostic culturally adapted CBT with Farsi-speaking refugees: A pilot study. *European Journal of Psychotraumatology*, *8*, 1–10.

Kazantis, N., Deane, F. P., & Ronan, K. R. (2005). *Using homework assignment in cognitive behavioral therapy*. Brunner-Routledge.

Keysar, B., Hayakawa, S. L., & An, S. G. (2012). The foreign-language effect: Thinking in a foreign tongue reduces decision biases. *Psychological Science*, *23*(6), 661–668.

Koven, M. (2001). Comparing bilinguals' quoted performances of self and others in tellings of the same experience in two languages. *Language in Society*, *30*(4), 513–558.

Marcos, L. R. (1976). Linguistic dimensions in the bilingual patient. *The American Journal of Psychoanalysis*, *36*(4), 347–354.

Marian, V., & Kaushanskaya, M. (2004). Self-construal and emotion in bicultural bilinguals. *Journal of Memory and Language*, *51*(4), 190–201.

Marshall, P. A., Koenig, B. A., Grifhorst, P, & van Ewijk, M. (1998). Ethical issues in immigrant health care and clinical research. In S. Loue (Ed.), *Handbook of immigrant health* (pp. 203–226). Plenum Press.

Muñoz, R. F., & Miranda, J. (2000). *Group therapy manual for cognitive-behavioral treatment of depression*. Rand Corporation.

OECD/ILO/IOM/UNHCR (2018). *G20 international migration and displacement trends report*. http://www.oecd.org/els/mig/G20-international-migration-and-displacement-trends-report-2018.pdf

Panicacci, A., & Dewaele, J.-M. (2017). "A voice from elsewhere": Acculturation, personality and migrants' self-perceptions across languages and cultures. *International Journal of Multilingualism*, *14*(4), 419–436.

Pavlenko, A. (2004). "Stop doing that, Ia Komu Skazala!": Language choice and emotions in parent-child communication. *Journal of Multilingual and Multicultural Development*, *25*(2–3), 179–203.

Pavlenko, A. (Ed.). (2006). Bilingual minds: Emotional experience, expression and representation. Multilingual Matters.

Pratt, R., Ahmed, N., Noor, S., Sharif, H., Raymond, N., & Williams, C. (2017). Addressing behavioral health disparities for Somali immigrants through group cognitive behavioral therapy led by community health workers. *Journal of Immigrant and Minority Health*, *19*(1), 187–193.

Rintell, E. M. (1984). But how did you feel about that? The learner's perception of emotion in speech. *Applied Linguistics*, *5*(3), 255–264.

Sharf, R. S. (2015). *Theories of psychotherapy and counseling* (6th Edition). Cengage Learning.

Sroufe, A. L. (2000). Early relationships and the development of children. *Infant Mental Health Journal*, *21*(1–2), 67–74.

Sue, D. W., & Sue, D. (2019). *Counseling the culturally diverse: Theory and practice* (8th Edition). Wiley.

Tannenbaum, M. (2012). Family language policy as a form of coping or defense mechanism. *Journal of Multilingual and Multicultural Development*, *33*(1), 57–66.

Tribe, R., & Lane, P. (2009). Working with interpreters across language and culture in mental health. *Journal of Mental Health*, *18*(3), 233–241.

Tribe, R., & Sanders, M. (2003). Training issues for interpreters. In R. Tribe & H. Raval (Eds.), *Working with interpreters in mental health* (pp. 54–68). Brunner-Routledge.

Weiss, B. J., Singh, J. S., & Hope, D. A. (2011). Cognitive-Behavioral Therapy for immigrants presenting with social anxiety disorder: Two case studies. *Clinical Case Studies*, *10*(4), 324–342.

Winnicott, D. W. (1990). Ego distortion in terms of true and false self. In *The maturational processes and the facilitating environment* (pp. 140–152) (original version, 1960). Karnac Books.

Zeedyk, M. S. (2006). From intersubjectivity to subjectivity: The transformative roles of emotional intimacy and imitation. *Infant and Child Development*, *15*(3), 321–344.

Author biographies

Michal Tannenbaum is a senior lecturer and the head of the Program for Multilingual Education, School of Education, Tel Aviv University. Her research interests include psychological and emotional aspects of immigration and multilingualism, linguistic patterns of minority groups, the exploration of meeting points between language issues and arts, and educational language policy.

Eden Har holds an MA degree in Education (specializing in children with special needs) from Tel Aviv University. She is a CBT therapist, using also dynamic approach for emotional difficulties, especially with children diagnosed with ADHD.