

Language and Cognitive Behavioural Therapy Practice Paper-Literature Review and Case Example

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Abstract

This paper addresses the impact of language on cognitive behavioural therapy. Language is emotive and studies carried out in the linguistic field have shown second language is less emotive when describing events occurring in the first language. This paper has been written based on the experiences of a cognitive behavior therapy (CBT) service providing therapy to patients from a diverse cultural and ethnic population. Patients whose first language is not English often receive therapy in their second language. Global migration is a common phenomenon and mainly occurs for economic reasons or threat of violence. This paper has been drawn from the results of a literature review on first and second languages and therapy. Despite being an area that is extremely relevant to therapy, there is an apparent lack of literature in relation to cognitive behavioural therapy for depression and other disorders. CBT is one of the recommended therapies by National Institute of Health and Clinical Excellence (NICE) for the treatment of depression and anxiety disorders. Findings from the linguistic field highlight the potential shortcomings providing therapy in a patient's second language. The aim of this paper is to highlight the importance that therapists working in this field have an understanding of how first and second languages function and the role they play in maintaining patients' psychological problems. This practice paper discusses measures that can be used in cognitive behavioural therapy to deal with this using a case example.

Key Words: Cognitive behavioural therapy, language, linguistic

Özet

Dil ve Bilişsel Davranışçı Terapi Uygulama Yazısı- Literatür Gözden Geçirmesi ve Olgu Örneği

Bu yazıda dilin bilişsel davranışçı terapi (BDT) üzerindeki etkisi ele alınmaktadır. Konuşulan dil bir duygu yoğunluğu taşımaktadır ve linguistik alanda yapılan çalışmalar ana dilimizde deneyimlenen duyguların ikinci dilde ifade edildiğinde daha az duygu yükü taşıdığını göstermektedir. Bu yazı çeşitli kültürel ve etnik popülasyondan gelen hastalara BDT hizmeti veren bir servisin deneyimlerine dayanılarak yazılmıştır. Ana dili İngilizce olmayan hastaların birçoğu konuştukları ikinci dilde terapi almaktadır. Küresel göçler sık görülürler ve daha çok ekonomik nedenler veya şiddet tehdidi yüzünden gerçekleşmektedir. Bu yazı birinci ve ikinci dillerde yapılan terapilerle ilgili literatürdeki gözden geçirmelerin sonuçlarından yararlanılarak yazılmıştır. Terapi ile son derece ilgili bir alan olmasına rağmen depresyon ve diğer bozukların bilişsel davranışçı terapisi ile ilgili literatürde eksiklik bulunmaktadır. Depresyon ve anksiyete bozukluklarında BDT, Ulusal Sağlık ve Klinik Uygulamalar Enstitüsü (USKUE) tarafından önerilen terapilerden birisidir. Linguistik alanda yapılan çalışmalar hastanın ikinci dilinde yapılan terapilerin potansiyel eksikliklerini vurgulamaktadır. Bu yazının amacı alanda çalışan terapistlerin anadil ve ikinci dilin nasıl işlev gördüğünü anlamalarının önemini ve dilin hastaların psikolojik problemlerinde nasıl bir rol oynadığını vurgulamaktır. Bu gözden geçirme yazısı bilişsel davranışçı terapidaki bu problemlerle başa çıkabilmek için kullanılabilecek yöntemleri bir olgu örneği üzerinden tartışmaktadır.

Anahtar Kelimeler: Bilişsel davranışçı terapi, dil, linguistik

Introduction

Over the last 40 years the United Kingdom's population demographics have changed dramatically as a result of migration. This has had the effect of making major

British cities much more ethnically and culturally diverse (Glover et al. 2001). Mental health services established for the local population have had to cater for the demands and needs of migrants. One of the challenges faced by mental health services in meeting

these needs has been the provision of services to those whose have a limited or poor command of English. In attempting to overcome this challenge, services have employed interpreters or health advocates to bridge the communication gap between patients and mental health professionals.

Psychological treatments are an essential part of comprehensive mental health services. Over the last 10 years, with the establishment of the National Institute of Health and Clinical Excellence (NICE), there has been a dramatic change in the range of therapies offered; NICE guidelines have recommended evidenced based therapies, one of which has been Cognitive Behavioural Therapy (CBT) (NICE, 2002, 2004a, 2004b, 2005a, 2005b, 2010). CBT remains one of the most researched psychotherapies (Butler et al. 2006, Hoffmann and Smits 2008) in terms of its treatment efficacy for a wide range of psychological disorders. However, there is little or no research on the relationship between first and second languages and cognitive behavioural therapy. In the linguistic field extensive studies have been carried out showing what appears to be a relationship between the first and second languages and emotions (as discussed below). This potentially has a negative effect in therapy when attempting to work with patients who are bilingual and whose first language is not English.

This article has been written to highlight the importance of understanding the role of first and second languages and their impact in the field of CBT. A literature metasearch was carried out during the literature review utilising search engines that access the standard mental health related bibliographic databases (MEDLINE, CINAHL and PsycINFO) and Google Scholar. The Patient Intervention Comparison and Outcomes (PICO) (Richardson et al. 1995) is a widely used search method for information relating to clinical queries by clearly defining the patient population or problem, interventions, comparison and outcomes. The searches were conducted using the key terms “first language”, “second language”, “depression”, “cognitive behavioural therapy”, “affect” and “emotion”.

Theme 1: Language, emotion, memory and mood

In the past decade, the relationship between language, cognition and emotion has come to the forefront in the study of cognitive linguistics, neurolinguistics, cognitive and cultural psychology and linguistic anthropology (Palmer and Occhi 1999, Wierzbicka 1999, Le Doux 2003). Linguistic theory suggests a

link between language and emotion. Language is the primary means through which emotions are labelled and later expressed (Altarriba 2003). In studies carried out by Dewaele (2004) and Harris et al. (2006) they found that bilinguals reported their first language to be “their most emotional language”. Languages are not directly interchangeable, meanings may be encoded, emotionally processed and internalised in one language while remaining inaccessible in another (Antinucci 2004).

Testimonials from patients undergoing psychotherapy (Marian and Neisser 2000, Schrauf and Rubin 1998) stated that they experienced a greater emotional arousal in their first language compared to their second. An older study (Gonzalez-Reigosa 1976) reported that Spanish-English bilingual patients used English (their second language) when discussing anxiety provoking topics as a distancing technique, these patients used Spanish when discussing topics which were emotionally comfortable and allowed them to express self confidence, calm and emotional reserve. In this study, alternating between the first and second language appears to serve the purpose of reducing emotional distress. Other studies (Bond and Lai 1986, Dewale and Pavlenko 2002, Pavlenko 1998, 1999, 2002) have shown that individuals find it easier to discuss embarrassing topics in their second language rather than their first. Marcos (1976) named this emotional detachment that bilinguals have in their second language as detachment effect. In his theory, Marcos elaborated that the second language serves as an intellectual function and is relatively devoid of emotion whereas the first language expresses the emotional context.

In a study by Anooshian and Hertle (1994) on emotional reactivity to words in the first and second languages, they found higher emotionality on recall in the first language. Studies have also shown that bilinguals' language may influence their cognitive styles as they express more intense affect when speaking the same language at the time of retrieval as to the time when the event took place (Marian and Kaushanskaya 2004). Often patients access psychological help some time after the initial event has occurred. In the case of refugees this may be in their host country and only after a period of settling in when they have knowledge of the services they can access help through. An earlier study carried out by Blaney (1986) demonstrated the negative affective state evoking mood congruent cognitions; this is important in therapy as the core element in CBT is addressing these negative cognitions.

Autobiographical memory consists of the recall of events related to one's own life and belongs to the episodic memory category (Tulving 1983). Language serves as a feature to organise events stored in memory. Javier et al. (1993) found from their study that language can serve as a powerful retrieval function; a cue to events that have been experienced. Other studies carried out by Schrauf and Rubin (1998, 2000) have demonstrated that bilinguals have the ability to categorise autobiographical memories in their first and second languages dependent on the language spoken when the memory was stored. In addition, they noted that language encoding for events in one's life becomes a stable characteristic of memory. Marian and Neisser (2000) found that cues such as language that were present when the memory was encoded would be successful in retrieving the original event.

Mood and memory are interconnected. Mood congruent memory (Blaney 1986, Teasdale and Russell 1983) refers to the tendency for depressed individuals to have a preference for the encoding or retrieval of negatively valence information. As discussed above, findings from studies undertaken in the linguistic field attempting to understand the emotionality of the first and second languages have shown that the first language has a greater emotionality. Working in the second language may not evoke the appropriate emotions to help identify the underlying mechanisms present in the patient's current difficulties. It is important to consider that this may render therapy ineffective and result in disengagement of the patient from therapy.

Theme 2: Current practice

Currently patients who do not possess a competent level of spoken English are provided with psychological interventions through the use of interpreters or advocates within their therapeutic sessions. However, the use of interpreters is not always straightforward and creates its own issues. There has been resistance by therapist/counsellors to providing therapy using interpreters or advocates due to a range of concerns related to the therapeutic relationship and issues surrounding confidentiality (Gerrish et al. 2004). The development of trust and confidentiality between the patient and therapist is vital (Alexander et al. 2004) and working with interpreters changes the dynamics of the relationship between the therapist and patient. Tribe (2007) describes how some patients feel infantilised when the interpreter becomes their voice and communicates on their behalf.

The lack of training for both interpreter and therapist has affected engagement (Tribe 1999) as have differences in gender, age and religion between the interpreter and patient (Nijad 2003). Inconsistency relating to which particular interpreter is attending a session also has a negative impact on the therapeutic relationship, especially when trust and confidentiality have been established. This is usually a result of the way services are structured and provided rather than the interpreters themselves. Patients have also expressed legitimate concerns on the potential for breaching confidentiality when the interpreter belongs to the same community group. Marshall et al. (1998) and Tribe and Sanders (2003) have indicated that differences in regional dialects between interpreter and patient may also affect engagement and limit effective communication; there may also be issues relating to cultural hierarchy and social values that interfere with the therapeutic relationship (Bayes and Neill 1978).

Theme 3: Learning and age of acquisition of second language

Linguistic studies have found that language is acquired in early childhood at the same time as the development of emotional regulation (Bloom and Beckwith 1989). Silva (2000) explains that a mother tongue is likely to be used to code early experiences and that those thoughts and feelings are driven by the way the language was acquired and developed in that individual. The manner in which these emotional word labels are represented in memory is highly likely to be different to the words learnt later. In that, language learnt during early childhood and post puberty differs in emotional impact (Bloom and Beckwith 1989, Grosjean 1982), the first being the language in which personal involvement is expressed and the second is of distance and detachment (Amati-Mehler et al. 1993, Annoshian and Hertle 1994, Bond and Lai 1986, Gonzalez-Reigosa 1976, Javier 1989, Javier and Marcos 1989).

Individuals who learn one language exclusively for the first part of their life and later learn a second language (usually in a different context or location) are often referred to as coordinate bilinguals (Grosjean 1982). When an individual learns two languages simultaneously within the same context and timeframe e.g. education (formal) or from parents (naturalistic) who are bilinguals they are referred to as compound bilinguals (Grosjean 1982). Dawaele and Pavlenko (2003) state that naturalistic learning contexts also lead to more perceived emotional force

than formal instruction (such as being taught in school). Naturalistic learning tends to occur within natural environments and social settings such as the home; formal learning is bound by context in terms of the way instructions are delivered e.g. in school. The difference between coordinate and compound bilinguals is that compound bilinguals (Grosjean 1982) are more likely to code experiences in two languages and learn to label their thoughts and emotions using two language systems simultaneously.

Other research has shown that emotions are often shaped and influenced by the social and cultural context in which they are experienced rather than being solely the result of biological determinants (Campos et al. 1989, Lutz 1988). Kitayama and Markus (1994) note that cultural processes also work to organise and structure emotional experiences so descriptions of emotions may vary across cultures.

Implications for therapeutic practice

This literature review suggests that therapists working with patients from an ethnically and culturally diverse population require a greater understanding of the impact first and second languages have on therapy. Language is not only a tool for intellectual communication but also plays an important role in the expression and experience of emotions; language is key in establishing the therapeutic relationship through which both therapist and patient engage with the therapeutic process.

CBT is based on the hypothesis that individuals react to negative emotions based on inferences that are made during a particular situation (Beck 1976, Beck et al. 1979, Greenberger and Padesky 1995, Padesky and Greenberger 1995, Beck 2011). These researchers went on to state that such inferences stem from certain core beliefs that individuals hold about themselves, others and the world. This is important, as the aim of therapy is to help patients deal with painful emotions. When working with a patient in a second language there is potential for the second language to be used as a mechanism to avoid painful emotions as hypothesised by Marcos (1976).

Additionally, for some patients the second language may act as safety behaviour (Salkovskis 1996) to prevent the activation of traumatic memories. This is particularly significant when working with individuals who have experienced trauma in their first language and are receiving therapy in their second language. Foa and Kozak (1986), Foa and Riggs (1993), Foa et al. (1992) proposed their fear structures theory to assist

the understanding of post-traumatic stress disorder. This proposes the formation of fear networks (Lang 1977, 1986) in long-term memory and hypothesises that avoidance and suppression of the activation channels or networks leads to clustering of avoidance symptoms. Foa et al. (1986, 1993, 1992) proposed that successful resolution of the trauma occurs only with the integration of information in the fear network into existing memory structures.

Therapists need to be flexible when working with this patient group by working in both the first and second languages. Exploring in the first language and unpacking in the second would allow the associated meanings and emotions attached to the first language to be expressed and worked through in the second language. Additionally, therapists need to be creative when engaging patients in therapy and use non-linguistic techniques to help access their patients' salient emotional points.

By adopting this flexible approach enables services to ensure that patients whose first language is not English referred, have access to therapy. Additionally it promotes engagement and working effectively to ensure the patients psychological difficulties are dealt with in therapy effectively.

As area that under researched supervisors providing clinical supervision to therapist working with this client group need to be aware of the issues that may present in therapy and help develop therapist skills in supervision to work effectively with their patients. Learning can take place for both the supervisor and supervisee in supervision by the sharing of therapy experiences to develop creative ways of working with these patients.

In the longer term educational establishments providing training in CBT need to consider developing training for trainee and existing therapist on how to work with patients whose first language is not English. In addition to working in the first and second languages the training needs to include working flexibly and creatively when engaging with this patient group.

Case Example

Sakina is a 48-year-old widowed lady from Burundi. She came to the UK as a refugee after her husband and two sons were killed. When she arrived in the UK she was not able to speak English and this was limiting for her; she had great difficulty accessing services. The staff at the hostel where she was living encouraged her to undertake a course in English for

foreigners. She gained a sufficient level of proficiency to communicate her needs and access health services. Sakina was referred for CBT after an assessment by her GP who diagnosed her with depression. She was offered a CBT assessment in her second language and offered a course of therapy; her therapist did not speak her first language but worked with Sakina in both her first and second languages. The vignette below describes how her therapist explored feelings and beliefs in her both first and second languages.

Therapist: “What are you feeling now?”

Sakina: “I don’t know how to describe it.”

T: “Could you describe it in your first language, it is not important that I do not speak your first language but it would help me understand better what you are experiencing and I can explore that with you.”

S: Describes in the first language.

T: “Having just described that what do you feel now?”

T: “Where do you feel it in your body?”

S: Points to the chest.

T: “What does that feeling mean to you?”

S: “I am bad” in her first language.

T: “Is there a word in English that you can describe that word?”

S: “Bad”

T: “When you say I am bad is that a feeling or you feel that you are a bad person”

S: “I am a bad person”

T: “In order not to feel bad, what do you do?”

S: “Helping others”

T: “Am I right in understanding that in order not to feel bad you must help others”

S: “Yes”

T: “We can see how you have been helping others at the hostel to look after their children and cooking for them.”

T: “And if you were to help others what would that say about you?”

S: “I am good person.”

T: “So in a way you are saying that if I help others then I am a good person.”

S: “Yes.”

T: “When you try to help others all the time how does that affect you?”

S: “I have no time for myself and nothing gets done and I feel stuck.”

T: “How do you think by believing that if you help others then you are a good person maintain or keeps your problem going?”

The vignette above describes how the therapist worked with the patient in her second language and getting the patient to describe her experiences in her first language which allowed her to experience the emotions associated to the experience. By getting the patient to re-experience the emotions that were associated with the situation that occurred in the patient’s first language allowed the therapist to uncover the underlying assumptions associated with that specific experience. This facilitated the therapy to progress and help deal with her underlying assumptions effectively in therapy.

Conclusion

The relationship between first and second languages in the field of CBT has been poorly understood. Language is highly emotive and when working in a second language there is potential for losing the emotive component which is a vital element in therapy. In order to be able to deal effectively with the patients presenting problems it is imperative that appropriate emotions and beliefs are addressed. Therapists need to be adaptive when working with this patient group by being flexible and allowing patients to describe their experiences in their first language and to unpack the meanings in the second language. This enhances engagement and collaboration between patient and therapist. In the longer term training and supervision models need to be developed to equip therapist to work with this patient group. The roles of first and second languages in therapy need to be considered for future research.

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