CLINICIAN FACTORS IN INTERPRETER-FACILITATED PSYCHOTHERAPY:

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Abstract

In recent decades the number of persons in the US with limited English proficiency (LEP) has significantly increased. Research shows that persons with LEP experience higher rates of psychological distress and that LEP poses a significant barrier to accessing mental health treatment. As such, there is a growing need for psychotherapists to integrate foreign language interpreters into treatment. However, research is extremely limited on the use of interpreters in psychotherapy. Existing research focuses on challenges in treatment related to interpreter factors. Therapist factors and their effect on interpreter-facilitated treatment remain relatively unexamined. This study was undertaken to investigate how integrating interpreters into psychotherapy shifts the therapeutic process, with particular attention to therapist factors. A qualitative research design combining ethnographic and grounded theory was used. Eleven semi-structured interviews were conducted with psychologists experienced at conducting interpreter-facilitated therapy. Five major research questions were addressed: (1) How do therapists conceptualize interpreter-facilitated therapy in terms of the interpreter's role, their relationship with the interpreter, and the interpreter's relationship with the patient? (2) To what extent do therapists acknowledge and engage with interpreters' presence in interpreter-facilitated psychotherapy? (3) What emotions do therapists experience in reaction to working with interpreters and to what extent do they reflect on and process these reactions? (4) According to therapists, what should therapist training on interpreter-facilitated therapy entail? (5) Aside from interpreter factors, what challenges arise in interpreter-facilitated psychotherapy? The following qualitative themes emerged: the importance of on-going positive relationships between all therapy participants, clearly establishing the frame of therapy and defining roles, having regular pre-sessions and post-sessions, and therapist flexibility. Other themes included: therapists'

conceptualizations of the interpreter's role; therapists' emotional reactions to working with interpreters; systemic barriers and limitations; the myth of interpreter neutrality; and the need for therapist training in interpreter-facilitated therapy. The findings of this study suggest important implications for therapist training and practice, namely: the importance of being flexible; building collaborative relationships with interpreters; regularly communicating expectations and feedback with interpreters; and understanding the potential benefits of engaging the personhood of interpreters in the therapy process.

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Chapter I

Introduction

The number of people in the United States with limited English proficiency (LEP) has grown significantly in recent decades, as has the linguistic diversity and geographic dispersion of the LEP population. There are now higher numbers of LEP persons living in a wider variety of US localities and speaking a wider variety of languages than ever before (Migration Policy Institute [MPI], 2011; US Census Bureau, 2012). Empirical evidence suggests that mental health issues are more common among LEP populations (Brach, Fraser, & Paez, 2005; Searight & Searight, 2009; Snowden et al., 2007;) and that LEP poses a significant barrier to accessing mental health services (Gon-Guy, Cravens, & Patterson, 1991; Searight & Searight, 2009; Snowden et al., 2007; Wong et al., 2006). Furthermore, language discordance between patient and clinician has been shown to negatively affect the quality of care received by patients in numerous ways (Bamford, 1991; Doolgin, Salazar, & Cruz, 1987; Erzinger, 1991; Lee, 1997; Marcos, 1979; Paone & Malott, 2008; Raval, 2005; Santiago-Rivera, 1995; Seijo, Gomez, & Freidenberg, 1991). As such, there is an increasing need for therapists to integrate the services of foreign language interpreters into their work with patients.

Clearly, the integration of an interpreter into psychotherapy changes the dynamics and process in significant ways. However, the literature on working with interpreters in psychotherapy is extremely limited and consists mostly of opinions and anecdotes based on authors' clinical experiences. One theme repeated throughout the literature is that therapists perceive working with interpreters as problematic and have a variety of negative thoughts and feelings associated with it (Brisset et al., 2013; Kaufert & Koolage, 1984; Kline, Acosta, Austin, & Johnson, 1980; Miller et al., 2005; Raval & Smith, 2003; Roe & Roe, 1991; Tribe &

Morrissey, 2004). While there have been very few systematic studies on working with interpreters in psychotherapy, what research does exist has focused primarily on challenges and difficulties related to interpreter factors (such as their lack of adequate training, frequency of mistranslations, tendency to overstep role boundaries, etc.) and produced related suggestions for improving interpreter performance (Flores et al., 2003; Marcos, 1979; Paone & Malott, 2008; Searight & Searight, 2009). Alternately, a review of the literature found no research specifically focusing on therapist factors and how they affect the process of integrating interpreters into psychotherapy.

This qualitative study examines the process of interpreter-facilitated psychotherapy, from the perspective of experienced therapists. Its purpose was to explore the relational dynamics of interpreter-facilitated psychotherapy with a particular focus on therapist factors, in order to develop a more comprehensive understanding of the therapist's impact on the process. Furthermore the study sought to explore how experienced therapists collaborate with interpreters and integrate them into their therapies with the hope of clarifying how therapists can improve their interpreter-facilitated work. The study examined five major research questions:

1) How do therapists conceptualize interpreter-facilitated psychotherapy in terms of the interpreter's role, their relationship with the interpreter, and the interpreter's relationship with the patient?

2) To what extent do therapists acknowledge and engage with interpreters' presence in interpreter-facilitated psychotherapy?

3) What emotions do therapists experience in reaction to working with interpreters and to what extent do they reflect on and process these reactions?

4) According to therapists experienced in interpreter-facilitated psychotherapy, what should therapist training on working with interpreters entail?

5) Aside from interpreter factors, what challenges/obstacles arise in interpreter-facilitated psychotherapy?

Chapter II

Background: Review of the Literature

The Demand for Interpreting in Therapy

About twenty percent (20%) of people in the United States speak a language other than English in the home and about nine percent (9%) have limited English proficiency (LEP). In recent decades, immigration to the United States has surged, such that the US is now home to the largest immigrant population in the world. Moreover, increasing numbers of LEP individuals are foregoing historic immigrant destinations like New York or California to settle in nontraditional areas in the Southeastern, Southwestern, and Northwestern United States (MPI, 2011; US Census Bureau, 2012). In Nebraska, for example, nine percent (9%) of the population speaks a language other than English at home, an increase of over 40% since 1990 (Searight & Armock, 2013). Furthermore, as the LEP population has grown, so has its linguistic diversity. In other words, there are now higher numbers of LEP persons living in a wider variety of states and localities and speaking a wider variety of languages than ever before (MPI, 2011). All of these changes contribute to an increasing demand for interpreter services throughout the United States. Unfortunately, at present, there are significant obstacles to US healthcare agencies providing competent interpreter-facilitated care to LEP patients. For a number of reasons, these challenges are especially problematic with regards to mental health services.

First, research indicates that mental health issues are particularly salient among LEP populations. Studies show that LEP is more closely associated with the need for mental health treatment than the need for general medical care (Eibner & Strum, 2006; Snowden, Masland, & Guerrero, 2007). Furthermore, research suggests that individuals with LEP experience higher levels of psychological distress (Searight & Searight, 2009; Snowden et al., 2007) and are at

increased risk for depression (Brach, Fraser, & Paez, 2005) than those fluent in English. There are many possible explanations for this. The experience of living in a country where you do not speak the primary language – and so are cut off from a myriad of vital resources and employment opportunities – likely increases psychological distress. Issues like separation from family, struggles with acculturation, and experiences of racism or discrimination are also potential factors. Many LEP individuals may have come to the US due to poor conditions of one kind or another in their country of origin. Sometimes their travel to the US has been extremely difficult or even life-threatening. In the case of refugees and asylum seekers, patients have fled their homes due to ethnic, religious, or political persecution and are likely to be struggling with related post-traumatic symptoms. Whatever the source, the fact that persons with LEP tend to experience higher levels of psychological distress highlights the importance of offering psychological care to this population as well as the potential salience of language issues in such treatment.

Second, studies show that LEP poses a significant barrier to accessing mental health services (Gon-Guy, Cravens, & Patterson, 1991; Searight & Searight, 2009; Snowden et al., 2007; Wong et al., 2006). In fact, LEP proves more of an impediment in accessing mental health services than both ethnicity and health insurance status (Sentall & Shumway, 2004; Snowden et al., 2007). In 2004 Sentall and Shumway used the California Health Interview Survey (which offered a sample of 55,428 Californians) to conduct a comprehensive evaluation of LEP as a barrier to mental health treatment. They found that among persons expressing a need for mental health services, the receipt of treatment was significantly affected by level of English proficiency. Of those expressing a need for mental health care, fifty percent (50%) of those who spoke English "very well" received care, twenty-nine percent (29%) of those who spoke English

"well" received care, and only nine percent (9%) of those who spoke English "not well or not at all" received care (Sentall & Shumway, 2004, as quoted in Snowden et al., 2007, p. 111). These statistics reflect a significant disparity in provision of services to LEP persons. Furthermore, in their discussion of using interpreters in psychotherapy, Hamerdinger and Karlin (2003) assert that the barrier posed by LEP delays access to services such that by the time LEP patients do enter treatment, they are likely to be more severely impaired by mental illness.

Third, research has shown that LEP also affects the quality of care patients receive once they do access treatment. Studies have found that language discordance between patient and provider can cause under-diagnosis, more severe diagnosis, inappropriate treatment, low ratings of clinician empathy and support, lack of patient self-disclosure, poor patient retention, and patient distrust toward a providing organization (Bamford, 1991; Doolgin, Salazar, & Cruz, 1987; Erzinger, 1991; Lee, 1997; Paone & Malott, 2008; Marcos, 1979; Raval, 2005; Santiago-Rivera, 1995; Seijo, Gomez, & Freidenberg, 1991).

Alternately, when language barriers are effectively dealt with and language concordance (defined as clinician and patient sharing a language or the use of a qualified language interpreter) between patient and clinician is available, the quality of care for LEP patients is improved. Language concordance has been shown to lead to better access to health care, higher quality communication, increased patient satisfaction, fewer emergency room visits, and improved compliance to treatment plans (Eyton et al., 2002; Lee, Batal, Masselli & Kutner, 2002; Manson, 1988; Ramirez, 2003; Riddick, 1998; Stolk et al., 1998; Tribe & Lane, 2009; Tribe & Morrissey, 2004). There is also evidence that clients feel better understood and find it easier to discuss cultural and religious issues when a language interpreter is provided (Tribe & Thompson, 2009b). Considering all this, two things becomes clear: (1) At present, we are not providing

equal quality of care to patients with LEP, both in terms of access to mental health services and in term of quality of the services provided; and (2) there is a strong need to increase the effective use of interpreters in mental health service provision.

Ethical and Legal Requirements

Both the US Government and the American Psychological Association (APA) require effective integration of interpreting services in psychotherapy with LEP patients. Title VI of the 1964 Civil Rights Act (88th Congress, 1964) prohibits discrimination based on national origin and guarantees access to linguistically sensitive services. Title VI requires that agencies receiving funds from the Department of Health and Human Services (DHHS) – including Medicaid, managed care plans, and federally funded hospitals – provide LEP individuals, free of charge, the language assistance necessary to ensure equal access to services. Furthermore, in August 2000 the Clinton administration issued Executive Order 13166, echoing the imperatives of Title VI. The order affirmed the prohibition against discrimination based on LEP and re-stated the requirement for federally funded agencies to make reasonable language accommodations, including providing interpreters (Searight & Armock, 2013; Snowden et al., 2007).

Finally, in December of 2000, the DHHS's Office of Minority Health issued its "Culturally and Linguistically Appropriate Services Standards," a set of national standards for providing culturally and linguistically appropriate services for all recipients of federal funds (Snowden et al., 2007; US DHHS, 2001). Here too, the provision of a competent language interpreter is clearly mandated. Standard 4 states, "Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost,

to each patient/consumer with LEP at all points of contact, in a timely manner during all hours of operation" (US DHHS, 2001). In all of these mandates, securing a qualified interpreter is the responsibility of the service provider, not the patient (Mailloux, 2004; Searight & Armock, 2013).

In addition to the standards set by the federal government, the APA also calls for the provision of equal access to services for LEP patients. Principle D of the APA Ethics Code (APA 2002b) states that all persons are entitled to "equal quality in the processes, procedures, and services being conducted by psychologists." Principle E states that therapists must try not to allow bias related to culture, race, ethnicity, or language to impact their work. The APA's 2002 Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists state that multiculturally sensitive work will "respect the language preference of the client." Furthermore, APA standards (APA 2002b) stress the importance of therapist competence in all services they provide. According to Standard 2.01: Boundaries of Competence, psychologists may only provide services within the boundaries of their competence, based on their education, training, and experience. This implies that it is inappropriate for psychologists to work with interpreters when they have not undergone any training in how to do so.

Likewise, both the US Government and APA regulations specify that a qualified interpreter is necessary for appropriate service provision. The Department of Justice defines a "qualified interpreter" as "an interpreter who is able to interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary vocabulary" (Hamerdinger & Karlin, 2003, p. 2). The APA's Ethical Standards specifically mention interpreters in their discussion of the ethical delegation of professional activities. A psychologist is expected to limit

an interpreter's involvement to the activities that they can competently perform based on their

education, training, and experience. Finally, the APA explicitly states that friends and family

should not be used as interpreters, because no delegated services should be provided by a person

having a dual relationship with a client (APA 2002b; Searight & Searight, 2009).

Limits in implementation.

Despite the clear requirements in Title VI of the 1964 Civil Rights Act and the other

legislation described above that language services be provided in the care of LEP patients, the

literature indicates that there is a wide variation among state implementation of these policies.

There is little oversight or monitoring of state activities in this area and little research on the

effectiveness of different approaches to providing these services (Snowden et al., 2007). Some

states use thresholds to determine whether an agency must provide language services. In these

cases, if five percent (5%) or more of an agency's population has LEP, then language services

are deemed necessary for that site. Government funding for language services is also

inconsistent. Only about ten states pay for healthcare interpreting through Medicaid (Searight &

Searight, 2009).

Likewise, healthcare agencies are falling far short of providing necessary language

services. According to Lee (1997),

> Even in urban cities with large numbers of immigrants who do not speak English, many
> facilities have not dealt with language and cultural barriers in a formal operational sense
> and systematic way. Providing interpreters is not seen as an institutional responsibility.
> (p. 479)

The lack of a systematic approach to providing language services means that services are

not being provided to vast numbers of LEP patients, and that when they are provided, they rarely

involve the level of training or competence necessary for equal quality of care, both with regards

to the interpreter and the therapist. In a study of 234 hospitalized LEP patients, Schenker, Pérez-Stable, Nickleach, Karliner, (2011) found that only fifty-seven percent (57%) had any type of interpreter assist with their admission to the hospital and only sixty percent (60%) of LEP patients' treatment involved the use of an interpreter at any point. Furthermore, research suggests that the use of a certified or trained interpreter is rare (Schenker et al., 2011). It is more common for agencies to call on friends or family members of clients or on bilingual staff to serve as interpreters (Lee et al., 2006; Schenker et al., 2011). Ad-hoc interpreters such as these typically lack the complex skills necessary to function as qualified interpreters and often present dual relationships, which complicate and bias the interpretation process (Searight & Armock, 2013).

Moreover, despite the APA ethics code regarding boundaries of competence, training for therapists on working with interpreters is a relatively neglected aspect of service provision (O'Hara & Akinsulure-Smith, 2011). A review of the literature found that, though multiple articles recommended training for therapists on how to work with interpreters, there was virtually no mention of therapists having undergone such trainings.

Finally, it is important to recognize the oppression that is perpetuated by society's failure to prioritize the needs of LEP patients. Drennan and Swartz (2002) argue the on-going failure of institutions to recognize the communication needs of patients must be seen in the context of historical racism. They assert that clinical work in the context of impaired provider-patient communication perpetuates dehumanizing stereotypes and racist discourses in psychiatry through silencing and obscuring the patient populations that need interpreters. Likewise, Tribe & Lane (2009) state, "failure to tackle communication problems through the routine provision of

interpretation and advocacy services could lay the health service open to the charge of institutional racism" (p. 237).

Interpreter Training

Thus far, research on medical and mental health interpreting has focused largely on the importance of training for interpreters and the current deficit in such training (Flores et al., 2003; Marcos, 1979; Paone & Malott, 2008; Searight & Searight, 2009). It is a common misconception that being fluent in two languages is all that is necessary to perform as an interpreter (Hamerdinger & Karlin, 2003). The role of the interpreter calls for a far more sophisticated and complex set of skills than mere language ability. Effective performance as an interpreter requires knowledge of specialist terminology, an ability to reflect on meaning, memory skills, and knowledge of issues of confidentiality. Performance as a mental health interpreter requires additional skills on top of these, such as an ability to convey emotions expressed, an understanding of therapeutic boundaries, knowledge of ethical issues, and skill in dealing with conflict among others (Tribe and Morrissey, 2004).

Research has found that working with untrained interpreters can lead to a multitude of negative effects. In an early study by Marcos in 1979, psychiatric interviews conducted with interpreters untrained in mental health work were audio-taped and analyzed. Interpreters in this study expressed feelings of stress and annoyance at being assigned a task with "too much responsibility" (p. 172). They also expressed feelings of embarrassment about relaying sensitive patient information, such as sexuality issues. Psychiatrists involved in the study claimed that these negative attitudes and feelings would influence interpreters, leading to their inadvertent distortion of communications. Marcos's analysis of the tapes revealed multiple imperfect

translations which led to distortions and misunderstandings. He concluded that there is a significant risk in using untrained interpreters (Marcos, 1979; Paone & Malott, 2008).

In a study in 2003, Flores et al. found that untrained interpreters misinterpret or omit up to fifty percent (50%) of physician questions, significantly impacting the quality of communication between patient and practitioner. Furthermore, studies have found that asking bilingual practitioners or administrative employees to take on interpretation work that is not in their job description increases their feelings of despondency and anger toward clinicians (Mathews, Johnson, Noble, & Klinken, 2000; Raval & Smith, 2003).

Research has overwhelmingly supported the conclusion that family members do not make good interpreters and that children, in particular, should not be used (David & Rhee, 1998; Ebden, Bhatt, Carrey, & Harrison, 1988; Launer, 1978; Lee et al., 2002; Tribe & Morrissey, 2004). This is for a number of reasons. First, family members lack training in the above-mentioned interpretation skills. Second, they are unlikely to be able to act impartially. Interpreters are generally expected to be neutral such that they interpret all information communicated. Family members may withhold or alter sensitive, and possibly key information, due to cultural expectations, family loyalties, or power differentials (Amodeo, Grigg-Saito, & Robb, 1997; Paone & Malott, 2008). Finally, the presence of family members – particularly children – may also influence what a patient is comfortable discussing, and lead a patient to withhold important information.

As rare as it is for an interpreter used in psychotherapy to have training in interpretation skills, it is even more uncommon for an interpreter to have any training in mental health interpreting, even when working in a mental health setting. Miller, Martell, Pazdirek, Caruth, & Lopez, (2005) found that among those interpreting in long-term psychotherapy, only about

twenty percent (20%) had any formal mental health training. In part, this is because the field of professional interpreting is, in some ways, still in its infancy. Essentially, there has still not been a nationwide standardization of interpreting (Tribe & Morrissey, 2004). Court-interpreting has the highest level of regulation and standardization, with most states requiring completion of a state-specific training/certification program in court interpreting in order to work as a court interpreter. Certification programs in medical interpreting are also fairly prevalent in the US, but these are not necessarily required by hospitals in order to interpret. The role of the mental health interpreter is even less clearly defined and regulated. Though a few certification programs in mental health interpreting do exist (about four nation-wide), there is no standardization of mental health interpreting in the US. The role of the mental health interpreter is not yet adequately developed for trainings to be consistent or readily available.

According to Searight & Searight (2009), most interpreter service agencies consider mental health interpreting a subset of medical interpreting – something an interpreter can add as a specialization if they want to. Considering that there is little salary differential between interpreters with specialized mental health training and those with merely general medical interpreting training (Searight & Searight, 2009), it is no wonder that so few bother to specialize.

Still, for a number of reasons, interpreting in the context of therapy puts a different set of demands on an interpreter than medical interpreting. As such, it requires a different set of skills. In their discussion of the quality of care provided to LEP patients versus non-LEP patients, Snowden et al. (2007) note the unique challenges in providing mental health services. They state, "A particular focus on mental health is justified because mental health conditions are especially stigmatizing, opportunities for cultural misunderstanding are particularly great, and mental health treatment is highly specialized" (p. 110). On top of these challenges, both the

ongoing nature of the relationship and the extremely emotional material discussed make mental health interpreting distinct from medical interpreting (Miller et al., 2005; Tribe & Thompson, 2009b), such that it calls for specialized training.

Therapist Training

A review of the literature found no research that specifically focused on training for therapists on working with foreign language interpreters in psychotherapy. One study was found that related to the prevalence of training for medical residents as to the use of interpreters with LEP patients. In a survey of 3,435 medical residents in 149 different US hospitals, Lee et al. (2006) found that thirty-four percent (34%) had received very little or no instruction on delivering services effectively through a medical interpreter.

Numerous articles were found, however, whose conclusions suggest a need for clinician training on working with interpreters. Despite the tendency in the field to focus on interpreter mistakes and inadequacies, research shows that problems arise from lack of training of both interpreters and medical providers. In 2004 Gerrish, Chua, Sobowale, & Birks found that inadequate training of nurses as well as interpreters adversely affected the quality of interpreter-facilitated medical interactions. In a qualitative study involving semi-structured interviews with clinicians and interpreters, Miller et al. (2005) concluded that therapists should receive training in how to work effectively with interpreters. They further noted that therapists frequently experience a myriad of negative feelings and resistances in reaction to their interpreter-facilitated work, and that these would make a valuable set of foci for such training. Supporting this assertion, a study by Stolk et al. (1998) found that training health professionals to work with interpreters increased their readiness and willingness to do so. Likewise, in a systemic review of

61 qualitative studies on interpreting in healthcare, Brisset, Leanza, and Laforest (2013) concluded that training for clinicians is needed for them to competently incorporate interpreters into their work.

Finally, most articles commenting on the need for therapist training were based on authors' reflections on their own experiences in interpreter-facilitated work. Searight and Searight (2009) note that providing psychological services through an interpreter raises linguistic, diagnostic, cultural, and ethical dilemmas above and beyond those encountered in traditional therapy, highlighting the need for additional training. Likewise, Tribe and Morrissey (2004) report that effective collaboration with interpreters requires that therapists acquire new skills. Tribe and Thompson (2009b) state that engaging in a three-way relationship is unfamiliar for many therapists and that clinical training and supervision for a therapist working with interpreters should explore the relational aspects of the three-way relationship. Tribe and Sanders (2003) gave specific training recommendations for therapists, asserting that it should include guidance on briefing the interpreter, education on interpreter approaches, and active consideration of the attachment issues that may arise between client and interpreter. Unfortunately, despite the number of articles asserting the need for therapist training, little has been done in the field to systematically prepare therapists for working with interpreters (O'Hara & Akinsulure-Smith, 2011; Raval & Smith, 2003; Searight & Searight, 2009).

Current Models of Interpreting

Within the current interpreting community, there are differing approaches to the role of interpreter and different options in terms of the techniques used. A couple of basic differences in interpreting technique include simultaneous versus sequential interpreting and remote versus

proximate interpreting. In simultaneous interpreting, an interpreter translates and communicates

client speech as clients are talking, a word or two behind them. In sequential interpreting, the

interpreter waits for a pause in speech and then interprets what has been spoken before clients

continue. In proximate interpreting, the interpreter is physically in the room with the clients,

whereas in remote interpreting, the interpreter is accessible from a distance, via phone (Searight

& Searight, 2009).

Beyond these logistical differences, there is significant variability in how the role of the

interpreter is conceptualized. Multiple models of interpreting exist, and a number of different

labels tend to be used to describe each. However, most approaches fall into one of the following

basic categories: linguistic/black box, psychotherapeutic/constructionist, advocate, and cultural

broker (Tribe & Morrissey, 2004).

The linguistic model, also known as the "black box," or "conduit" model, emphasizes

verbatim translation and the neutrality of the interpreter. Its various labels highlight the fact that

the interpreter is essentially expected to act as a language machine. In this model, interpreters

are expected to maintain a distance from clients and perform in such a routine way that they are

essentially inter-changeable (Lee, 1997; Miller et al., 2005; Searight & Armock, 2013; Tribe &

Morrissey, 2004). Though Searight & Armock (2013) opine that his model is generally

considered "less than optimal" by both patients and interpreters (p. 25), other sources suggest

that this model, or at least the spirit of the model, is still a significant influence in the field. For

example, in their recommendations for working with interpreters, O'Hara and Akinsulure-Smith

(2011) present a sample transcript for defining roles and setting the frame of therapy in which

they "request black box interpretation" (p. 36). Likewise, Miller et al. (2005) outline a number

of ways that current practice recommendations serve to re-enforce the mechanization of interpreting (discussed further below).

The psychotherapeutic or constructivist model emphasizes the importance of the interpreter conveying the meaning of words and their accompanying emotion, rather than verbatim translation. In the advocate model, the interpreter not only assists linguistically, but serves as an active advocate for a patient, seeking services for them and potentially offering advice (Searight & Armock, 2013; Tribe & Morrissey, 2004).

Finally, the cultural broker model is the most commonly used model of interpreting in therapy (Searight & Armock, 2013; Tribe & Lane, 2009). In this model an interpreter is expected to provide relevant cultural education and context to therapists. They elucidate cultural meanings and significance in patients' words or behavior that might not be readily apparent to therapists due to cultural differences (Searight & Armock, 2013; Tribe & Lane, 2009; Tribe & Morrissey, 2004). Some theorists also describe the cultural broker role as involving interpreters acting as "therapy conduits" (Miller et al., 2005, p. 31) or "socializing agents" (Searight & Armock, 2013, p. 32) who directly and indirectly normalize psychotherapy and affirm its value for patients who come from cultures in which psychotherapy is unfamiliar or stigmatized.

Role Confusion and Setting the Frame of Therapy

Numerous articles assert the importance of defining roles and setting the frame of interpreter-facilitated therapy (Lee, 1997; O'Hara and Akinsulure-Smith, 2011; Paone & Malott, 2008; Tribe & Lane, 2009; Tribe & Morrissey, 2004; Tribe & Thompson, 2009b). Tribe and Morrissey (2004), for example, state that establishing a working contract at the onset of work that covers confidentiality, roles, responsibilities, and boundaries helps the therapy proceed as

smoothly as possible. O'Hara and Akinsulure-Smith (2011) assert that it is imperative that the

therapist clarify the frame of therapy, the role of the interpreter, confidentiality, and therapeutic

boundaries with both the interpreter and the patient at the onset of treatment.

Despite the recognition in the field of the importance of role clarity, research shows that

therapists, patients, and interpreters all frequently struggle with confusion and ambivalence

regarding the interpreter's role in treatment. In a meta-ethnographic analysis of the existing

literature on working with interpreters in healthcare settings, Brisset et al. (2013) report that

clinicians frequently place contradictory demands on interpreters over the course of their work

together. Likewise, they found that interpreters tend to feel conflicted about how to manage

these inconsistent role demands. For example, they note that, though often required to be neutral

and invisible, interpreters may also be expected to provide emotional support and cultural

brokering. Similarly, while many clinicians prefer to maintain interpreter consistency

throughout a treatment in order to establish safety and trust, some come to view consistency as

an obstacle when interpreters begin to claim expertise based on their growing experience.

Similarly, Raval and Smith (2003) report that clinicians express contradictory wishes regarding

the role of the interpreter. They describe participants asserting both that they wish for

interpreters to be forthcoming in offering their opinions about what is happening in session and

that they also experience interpreters sharing their opinions as intrusive. Likewise, according to

O'Hara and Akinsulure-Smith (2011) interpreters often complain that, despite their efforts to

adhere to the boundaries of their professional role, therapists sometimes ask them to break these

boundaries, pulling them more into the role of clinician.

Other research has also noted that interpreters may overstep their roles, causing tension

with providers. Role ambiguity has been found to contribute to feelings of disempowerment on

the part of both therapists and interpreters, to contribute to difficulties forming a positive

interpreter-therapist alliance (Raval & Smith, 2003), and to negatively affect the quality of

interpretation (Lee, 1997). In a study examining the effect of interpreters on the diagnostic

process in medical encounters, Hsieh (2007) found that interpreters often "systematically and

intentionally enact behaviors that overlap with providers' responsibilities and services" (p. 925).

Current Guidelines

The literature offers a number of clinical guidelines and recommendations for therapists

working with interpreters, however, these are based largely on anecdotal experiences or

adaptations of medical interpreting. There is little empirical research supporting these guidelines

(Searight & Armock, 2013). While there are some variations in what different sets of guidelines

cover, most agree on the following recommendations (Hamerdinger & Karlin, 2003; Lee, 1997;

O'Hara & Akinsulure-Smith, 2011; Paone & Malott, 2008; Searight & Searight, 2009; Tribe &

Lane, 2009; Tribe & Morrissey, 2004):

1) Whenever possible, a patient's first language or preferred language should be used, rather than a dominant language. This means that when working with a patient from Mauritania who speaks some French but is most comfortable speaking Wolof, it is preferable to work with a Wolof interpreter rather than a French interpreter, despite the fact that a French interpreter may be easier to find and the patient is able to communicate in French.

2) No family or friends should be used as interpreters, and it is inappropriate to ask bilingual co-workers to serve this role when it is not in their job description.

3) Effort should be made to match an interpreter's age, gender, religion, etc., with that of the patient.

4) Whenever possible, the same interpreter should be used throughout a course of therapy.

5) Clinician should be sure to pace speech such that the interpreter has time to interpret, and should encourage the patient to do the same.

6) Therapists should avoid using technical language, idioms, or jargon.

7) Interpreters should use the first person when communicating the speech of others, rather than stating "he/she said."

8) Therapists should speak directly to and make eye contact with the patient (rather than speaking to the interpreter about the patient). Likewise, therapists should explicitly encourage the patient to speak to and make eye contact with them rather than the interpreter.

9) As much as possible, all communication during session should be made transparent to all parties. Side conversations between the patient and interpreter should be discouraged and may contain information that is important for the therapist to know. As such, the therapist should ask the interpreter to repeat anything said in side conversations. Likewise, any communications between the therapist and interpreter should be clarified to the patient.

10) Pre-session and post-session meetings between interpreter and therapist should be used to review what is expected in an upcoming session, collaborate on treatment, debrief about a previous session, gain interpreter insights that may not have been communicated during the session, and to offer support to the interpreter.

11) Therapists have a responsibility to be alert to the possibility of interpreter vicarious traumatization, to help interpreters de-brief after sessions, and to ensure that any support they need is available.

Limitations of current guidelines.

Matching and the assumption of sameness.

There are a number of issues in the current guidelines which warrant further exploration. First, the emphasis on matching may represent an oversimplified understanding of a complicated issue. Multiple sets of guidelines state that matching a patient with an interpreter similar in gender, age, race, religion, etc. is beneficial to the therapeutic process (Paone & Malott, 2008; Tribe & Morrissey, 2004). Tribe and Morrissey specifically state that the presence of a fellow national or member of a familiar community can increase a patient's feelings of trust or belonging. However, matching may also feed into an assumption of sameness – the expectation that because people have certain traits in common, they also have the same views, beliefs, experiences, etc. Though they recommend matching, Paone and Malott also caution that, "Individuals who speak the client's language may not necessarily understand his or her culture or

sociopolitical context and, therefore, may misinterpret dialogue or behaviors" (p. 136).

Particularly when interpreters are expected to function as cultural brokers between patient and

therapist, matching has the potential to shut down exploration of culture and meaning, rather than

enhance it. Tribe and Thompson (2009b) state that a "lack of fit" (p. 6) between therapists,

interpreters, and patients creates opportunity for exploration and helpful reframing of

experiences. According to them, when there is a lack of fit, more energy is expended in

examining beliefs, assumptions, and meaning, such that new perspectives can be actively co-

created. Similarly, O'Hara and Akinsulure-Smith (2011) state that having the interpreters shed

light on a client's culture "circumvents the clinical utility of having the client tell the therapist

about their culture and their own experience within that culture" (p. 38). In addition, Smith,

Keller, & Lhewa (2007) note that matching is often inappropriate in the case of refugees and

asylum-seeking patients, who may struggle with fears that interpreters from their home countries

secretly work for those who persecuted them or that these interpreters agree with oppressive

views common in their countries' of origin.

Use of the first person and seating arrangements.

Other current guidelines are potentially problematic for another reason; they appear

designed to minimize the presence of the interpreter. As noted above, there is ambivalence and

controversy in the field as to the role of the interpreter in treatment. Despite use of the first

person being widely regarded as best practice in interpreting, there is some evidence to suggest

that this view may be shifting. For example, in the online discussion group of the US National

Council on Interpreting in Health, some participants in July-August of 2002 expressed feeling

that insistence on use of the first person was "unnecessary" and served to "emphasize the myth

of the translation machine" (Bot, 2005, p. 244). Indeed, there are a growing number of practitioners who question the appropriateness of requiring interpreters to use the first person rather than the third person, seating them out of view, and limiting their speech to the expression of the thoughts of others. These theorists assert that such practices are efforts to sideline interpreters' presence and obscure their personhood in an unrealistic and potentially destructive attempt to create the illusion of a dyadic relationship (Miller et al., 2005; Tribe & Thompson, 2009a; Bot, 2005).

In 2005 Bot conducted a study exploring the use of the first person by interpreters in therapy through interviews with therapists, interpreters, and patients followed by the analysis of videotapes of six interpreter-facilitated psychotherapy sessions. In her theoretical discussion introducing the study, Bot (2005) explored the idea that the insistence on interpreters speaking "for" or "as" their clients is rooted in American norms of communication, which posit that when someone reports another person's criticism, the opinion comes not from the last speaker, but from the person quoted. She asserted that there is a connection between this world view and gravitation in the field of psychology towards the black box model of interpreting, stating, "Assuming that a 'reporting person' is not responsible for the reported words means that the conveyor is seen as an 'inert vessel' [merely] transmitting information" (p. 240). Bot emphasized that this concept will not necessarily feel salient to people from other cultures, and noted the contrasting stance embodied in the Arabic proverb, "The one who repeats an insult is the one insulting you" (p. 240). From this perspective, the person reporting another's speech is considered a "responsible messenger" (p. 241).

In her analysis of videotapes of six interpreter-facilitated psychotherapy sessions, Bot (2005) found that interpreters frequently use "direct reported speech," in which they preface their

translation of first-person speech with "he/she says," rather than repeating speech verbatim in the

first person (p. 258). She explained that interpreters use reporting verbs as a clarification for

patients as to whose words are being spoken and, in a way, as a defense of their separate

selfhood and a validation of their presence in the room. Furthermore, Bot (2005) reported,

> Findings do not reveal any reason not to include the use of a reporting verb at the
> beginning of rendition… nor does an occasional change from first to third person appear
> to compromise the interaction... [nor] alienate therapist and patient, but [rather] merely
> recognizes the interactive reality of this type of talk. (p. 238-259)

Bot reflected that opponents of allowing reported speech in interpreting tend to argue for

the importance of direct contact between therapist and patient, clinging to the myth that the

speakers are communicating directly. Along with a small number of others (Miller et al., 2005;

Tribe & Thompson, 2009a), she suggested that denying the three-party character of interpreter-

facilitated interactions may ultimately undermine the quality of those interactions. Bot (2005)

advocated for an "interactive model of interpreting, in which interpreters are viewed as active

participants in the dialogue" (p. 243).

Similar controversy has arisen in the field as to the best seating arrangement with

working with interpreters. Though no one seating arrangement is endorsed across guidelines

(Tribe & Morrissey, 2004), it is not uncommon for the triangle formation, in which the

interpreter is clearly visible to all parties, to be discouraged in an effort to minimize the presence

of the interpreter. Searight and Searight (2009) state that "1:1 interaction" between clinician and

patient "is facilitated by an appropriate seating configuration" and go on to caution against the

triangle configuration, stating that it leads to "interpreter-centered" interaction (p. 446).

Similarly, Paone and Malott (2008) suggest positioning the interpreter slightly behind the

therapist, in an apparent effort to minimize awareness of the fact that all verbal communication

must pass through them.

The Interpreter is a Real Person and a Presence in the Room

  The myth of neutrality.

  Despite many practitioners' gravitation toward the black box model of interpreting, there is much in the literature stressing that interpreters are not neutral machines and inevitably harbor emotions, opinions, personalities, etc. that influence treatment (Bot, 2005; Hamerdinger & Karlin, 2003; Lee, 1997; Miller et al., 2005; O'Hara & Akinsulure-Smith, 2011; Searight & Searight, 2009; Tribe & Morrissey, 2004; Westemeyer, 1990). Hamerdinger and Karlin (2003) assert that in interpreter-facilitated therapy "there is a third person in the room, bringing his or her own psychological baggage into a session; baggage that may reveal itself in subtle nuances during interpretation… [in] shading and skewing of the message… neutrality is a myth" (p. 2-5). Similarly, Bot (2005) states, "Interpreters are obviously not translation machines. They come to the task with feelings, opinions, memories, and preconceptions about psychotherapy" (p. 243). Furthermore, despite the common preference for interpreters to remain as neutral as possible, they have emotional reactions to clinical material, and at times these reactions show. Interestingly, one study found that though interpreters did sometimes exhibit emotional responses to patients' trauma histories, usually therapists did not feel that these reactions were disruptive to the process. Rather, they found that processing these interpreter reactions together with patients could be a positive therapeutic experience (Miller et al., 2005).

  Interpreter relational engagement with patients.

  Furthermore, the literature clearly states that patients experience interpreters as a human presence in session, and engage with them as such. Miller et al. (2005) state that "Although some therapists may prefer that interpreters aim for a kind of invisibility, it is evident that clients

regard interpreters as anything but invisible. Clients often have strong emotional reactions to interpreters" (p. 31). Others note that transference and countertransference related to the interpreter can be as much a part of the treatment dynamic as that relating to the patient or the therapist (Bot, 2005; O'Hara & Akinsulure-Smith, 2011; Tribe & Morrissey, 2004). Multiple practitioners have noted that the interpreter can serve as a positive attachment figure and a supportive presence for patients (Miller et al., 2005; Searight & Searight, 2009; Tribe & Thompson, 2009b). Tribe and Thompson (2009b) state that interpreters who have a history of migrating themselves can become role models and sources of hope for patients. Perhaps most importantly, research has repeatedly found that patients form strong relationships with their interpreters, whether or not therapists regard this as part of the interpreter's role in the therapy (Miller et al., 2005; Raval & Smith, 2003). Brisset et al. (2013) found that patients value trust and emotional closeness with interpreters and consider these an important dimension in interpreter-facilitated treatment. Furthermore, research shows that patients experience interpreters as important witnesses to their suffering and growth, such that the healing potential for witnessing is increased by the added presence of the interpreter (Miller et al., 2005; Searight & Searight, 2009; Tribe & Thompson, 2009a; Tribe & Thompson, 2009b).

The Myth of Perfect Translation and the Role of Language

The work of psychotherapy has traditionally relied heavily on language; so much so that it is often referred to as "talk therapy." Many therapists express concern over the likelihood of mistranslations on the part of the interpreter. Though research shows that mistakes do occur, it is also true that languages are actually not fully interchangeable, and so expecting interpreters to

offer verbatim translations is often unrealistic. Words and concepts in one language might not

exist in another (Tribe & Morrissey, 2004).

Furthermore, verbatim translation is not only unrealistic, but in many circumstances, it is

not ideal either. The exact relationship between meaning and language is a subject of some

disagreement among psychologists and philosophers, and has bearing on the idea of

mistranslations. Some feel people construct reality through language (Tribe & Lane, 2009).

Tribe and Morrissey (2004) state that "language bears a close relationship to particular ways of

constructing meaning that may not be shared across cultures, and may both reflect and shape

how the world is interpreted" (p. 131). Translating between languages can, in effect, mean

translating between two separate world views – the nuance of which could easily be lost in

efforts to restrict oneself to verbatim report of speech.

Tribe and Thompson (2009b) discuss two possible views of language; monological and

dialogical. A monological view sees language as having a rigid, fixed meaning, which can easily

be lost through interpretation. In the dialogical view, "meanings of words and expressions are

understood as being partly established between people in interaction" (p. 8). This sort of

meaning-making is particularly relevant to therapeutic work, in which therapists and patients

develop a shared lens and vocabulary through which to conceptualize and discuss patients'

history, problems, goals, etc. From the dialogical point of view, working with an interpreter in

session simply makes the establishment of meaning a three-person interaction. Furthermore,

Tribe & Thompson (2009b) point out,

> The problems often reported by clinicians tend to take a purely monological view of
> language, as if meaning must necessarily be lost by passing through a third party. In fact
> this is clearly not the case, and even when a therapist and client communicate in the same
> language the meaning between them may be unclear and misunderstood. (p. 8)

The findings of Brisset et al. (2013) also support a flexible, inclusive viewpoint on language and meaning-making in interpreter-facilitated therapy. In their meta-analysis of qualitative studies on working with interpreters in healthcare, they found that "discourse transformation processes" (p. 138) were not necessarily negative. They assert that at times, these adjustments are essential to communication in terms of expressing empathy, finding equivalent meanings, and coordinating speech. Moreover, they state that these "errors" are even used by some practitioners as relevant clinical material contributing to development of meaningful therapeutic narratives (p. 138).

Therapists' Reactions to Working with Interpreters

      Difficulties and negative reactions.

One repeated theme throughout the existing literature is that practitioners perceive working with interpreters as unpleasant and problematic (Brisset et al., 2013; Miller et al., 2005; Raval & Smith, 2003; Tribe & Morrissey, 2004). In research on clinician experiences in working with interpreters, with rare exception, therapists reported notably negative perspectives. Many focused on what was "lost to them" (Raval & Smith, 2003, p. 12) via translation, rather than reflecting on potential gains. Clinician frustrations seem to relate generally to two main aspects of the interpreter-facilitated experience: (1) the technical and linguistic challenges; and (2) the shift in roles and relationship dynamics (Raval & Smith, 2003).

In studies on clinician experiences working through interpreters, most clinicians expressed concerns about inaccuracies in translation. They spoke about their reliance on language when engaging in therapy, and how much working through an interpreter strains this method of engagement (Raval & Smith, 2003). They reported worries that interpreters were

summarizing, rather than reporting speech verbatim. Therapists also lamented the loss of spontaneity in sessions conducted through interpreters, feeling the delay in communication undermined their connection and the flow of the session. Clinicians complained that time and language constraints forced them to simplify their questions and interventions, making them feel restricted (Searight & Searight, 2009; Tribe & Thompson, 2009b).

Perhaps more salient than these technical difficulties, clinicians have also expressed, in a variety of ways, that working with an interpreter feels threatening to their traditional role as therapists. In various studies, therapists expressed feeling scrutinized and judged by interpreters in session, distanced from their clients, and hostile towards interpreters when they overstep their roles (Kaufert & Koolage, 1984; Kline, Acosta, Austin, & Johnson, 1980; Raval & Smith, 2003; Roe & Roe, 1991; Tribe & Morrissey, 2004). The issue of the client developing their primary alliance with the interpreter, rather than with the therapist, was consistently a concern of therapists working in interpreter-facilitated psychotherapy (Miller et al., 2005; Raval & Smith, 2003; Tribe & Morrissey, 2004).

In 2003 Raval and Smith conducted a qualitative study on the experiences of mental health practitioners who conduct assessments and therapy with the help of language interpreters. A myriad of negative therapist feelings emerged. All therapists reported difficulty establishing a coworker alliance with interpreters and many reported distrust of the interpreter. They expressed feeling that interpreters take over their work in session and form the primary alliance with the patient, leaving them in a peripheral position. Many reported feelings of anxiety, loss of control, and powerlessness to change the interpreter-contract conditions. They reported struggling with issues of role ambiguity and power.

In 2005, Miller et al. conducted a similar study also using qualitative interviews. They spoke with 15 interpreters and 15 therapists about their work with refugees. Again, they found that interpreters formed powerful relationships with their patients and that therapists experienced feelings of exclusion. Feelings of anger and frustration were also reported in relation to working with interpreters. They found that therapists struggled with self-consciousness and anxiety that their work was being evaluated by the interpreters. Miller et al. (2005) noted, however, that this sense of self-consciousness and being judged decreased as clinicians gained more experience working with their interpreters. Blackwell (2005) commented on this experience, noting that when clinicians first begin to work with interpreters they may have a tendency to project their own critical superego onto the interpreter.

Research also suggests that these negative feelings may influence the effort that therapists put into engaging with interpreters, and how they engage when they do. Paone and Malott (2008) state that the seeking of interpreter services for patients may be undermined by therapist doubts about working collaboratively with interpreters. Most strikingly, a study by Kline et al. in 1980 offers important insight into the potentially detrimental impact of therapists' negative perception of working with interpreters. The study found that therapists working with LEP patients believed those served without the use of an interpreter were more satisfied than those whose session included interpreter services. Patients themselves, however, reported better experiences when interpreters were used. Furthermore, therapists predicted that only thirty-one percent (31%) of patients served through an interpreter would want to return for further treatment; but in actuality, seventy-six percent (76%) of patients served through an interpreter asked to return. These mistaken therapists went on the refer patients to "overburdened" bilingual practitioners, rather than to refer them to continuing treatment via an interpreter (Kline et al.,

1980, p. 1532). Kline et al. concluded that these therapists projected their own discomfort in working with interpreters onto their patients. This is a clear example of therapists' negative feelings undermining the accuracy of their perception of patient experience and negatively influencing the therapist's professional behaviors.

Positive reactions and focusing on gains.

Despite the prevalence of therapists' negative feelings and perspectives regarding working with interpreters, research on therapist experience has also shown that some feel positive about working with interpreters (Miller et al., 2005). Likewise, in articles reflecting on their clinical experience, some authors emphasize what they feel is gained through working with interpreters, rather than what is lost.

In addition to the prevalence of negative emotions in reaction to working with interpreters, Miller et al. (2005) found that "therapists were highly appreciative of the interpreters with whom they worked" (p. 32). In particular, they found that therapists value having the interpreter present to share the intensity of patients' emotional experiences. These therapists asserted that the interpreter's presence increases the support available to both therapist and patient during these intense moments.

Tribe and Thompson (2009b) echo this sentiment and add that when dealing with traumatic material, the extra support provided by the interpreter can help to mitigate vicarious trauma. Tribe and Lane (2009) point out that working through an interpreter can lead to thoughtfulness about the use of language, help clinicians question previously held assumptions, and increase clinician appreciation of other world views and health beliefs. Tribe and Thompson (2009b) note that working through an interpreter causes therapists to become more alert to non-

verbal communication and reflect that the joint struggle between all three therapy participants to find the right words underscores the importance of developing a shared meaning, which otherwise might be taken for granted. Likewise, as opposed to feeling that the delays in interpreting undermine connection and flow, Tribe and Thompson (2009b) assert that working through interpreters gives them more time to think, allowing them to be more reflective about their interventions. Hamerdinger and Karlin (2003) also express appreciation for the complexity and opportunity created by an interpreter's presence. They state, "In many cases interpreters allow for opportunities for transference and countertransference that do not exist in dyads," and that this opens the door to "work that is not possible using any other approach" (p. 2).

Systemic Issues in Working with Interpreters

One of the major factors in the struggle to provide competent language services to LEP patients is the widespread devaluation of the interpreter. Though the role of the interpreter is incredibly complex and vital, they are rarely accorded the professional status they deserve and tend to be regarded as low-status employees (Lipton, Arends, Bastian, Wright, & O'Hara, 2002; Raval & Smith, 2003; Tribe & Thompson, 2009b). Tribe and Morrissey (2004) assert that interpreters frequently report experiencing a lack of respect from the agencies for which they interpret. Likewise, an Australian study focusing on interpreters' experiences found that many interpreters feel that they are "not regarded as professionals in their own right, but merely as an 'adjunct' or 'instrument'... [and] treated like a second class employee" (Lipton et al., 2002, p. 7). The skill set necessary to perform effectively as an interpreter is commonly underestimated (Brisset et al., 2013; Hamerdinger & Karlin, 2003; Paone & Malott, 2008). Even when trained

and certified, interpreters are not paid commensurate with their skills and expertise (Lipton et al., 2002; Raval & Smith, 2003; Tribe & Thompson, 2009b).

Furthermore, beyond failing to pay interpreters appropriately, agencies do not prioritize their work and fail to devote the time and resources needed to effectively integrate them into their services as a whole (Paone & Malott, 2008; Tribe & Morrissey, 2004; Tribe & Thompson, 2009b). Brisset et al. (2013) note multiple effects of the lack of institutional recognition, including lack of support from medical staff, inadequate space allotment, and lack of training for both practitioners and interpreters. Others note the tendency in the field to structure psychotherapeutic work without allowing enough time for pre-session and post-session meetings between the therapist and interpreter (Brisset et al., 2013; Raval & Smith, 2003). As noted above, the failure of agencies to prioritize the needs of LEP patients and the work of interpreters is reflective of systemic racism and oppression (Drennan & Swartz, 2002; Tribe & Lane, 2009). According to Brisset et al. (2013), the next step to improve the quality of interpreter-facilitated care is the acknowledgement and improvement of interpreters' working conditions. Raval & Smith (2003) state,

> Even when interpreting services are available, there is often reluctance on the part of healthcare practitioners to utilize them. In the absence of organizational structures and professional recognition to fully support the work of interpreters, this status quo is likely to be maintained. (p. 7)

Towards a More Collaborative Approach

Sharing power and control.

Though research on power dynamics in interpreter-facilitated therapy is extremely limited, what does exist suggests that interpreter-facilitated therapy may be best undertaken using a collaborative approach in which power is shared among therapy participants. Multiple

researchers have noted that integrating interpreters into treatment involves negotiating complex power dynamics (Brisset et al., 2013; Lee, 1997; Raval & Smith, 2003). In their meta-analysis of qualitative studies on working in healthcare settings with interpreters, Brisset et al. (2013) found that issues of trust, control, and power are a regular source of difficulties in interpreter-facilitated treatment. It is not uncommon for both clinicians and interpreters to struggle with feelings of disempowerment (Lee, 1997; Brisset et al., 2013; Raval & Smith, 2003). As noted above, clinicians often grapple with feelings of helplessness, fear that interpreters are taking over their roles, and/or worry that interpreters dominate their relationships with patients. Likewise, the literature notes that clinicians may try to compensate for the loss of power through becoming more rigid and controlling in session (Brisset et al., 2013; Lee, 1997). This, in turn, contributes to the disempowerment of the interpreter. Not surprisingly, such power differentials in the interpreter-therapist relationship have been found to undermine the working alliance and the establishment of trust between therapy participants (Brisset et al., 2013; Raval & Smith, 2003).

Furthermore, Raval & Smith (2003) caution that when therapists or interpreters feel disempowered, these emotions are likely to be mirrored for patients. Tribe and Thompson (2009a) state that how LEP patients experience these power dynamics in therapy is often reflective of their experiences of ethnic conflict between groups or their experiences of how power is negotiated at a societal level. They stress that it is essential for therapists to view what is happening in therapy through a wide lens which takes into account societal structures of power. Considering the marginalized position of persons with LEP and the prevalence of experiences of racism, oppression, and persecution among the LEP population, it is worth considering how these patients experience a therapeutic frame that systematically disempowers any of its participants.

All of this highlights the value of a collaborative, egalitarian approach in interpreter-facilitated therapy. Brisset et al. (2013) assert that for collaboration with interpreters to be successful, all therapy participants must balance the power and control in session. They state,

> If one of the protagonists attempts to take control, or if the institutional (or broader) context instrumentalizes or is unfavorable to interpreters, the quality of relationships can be affected. Any trust that has been established may be diminished, negatively influencing the quality of care. (p. 137)

Likewise, Raval and Smith (2003) assert that "all parties concerned need to feel empowered within the context of the therapeutic encounter" (p. 24).

The therapist-interpreter relationship.

Literature focusing on the interpreter-therapist relationship is quite limited. Only two systematic studies have been conducted that shed light on this topic. In their qualitative study on therapists' experiences working with interpreters, Raval and Smith (2003) found that all participants struggled to establish positive working relationships with interpreters; and that this, in turn, undermined their ability to establish alliances with their patients (Raval & Smith, 2003). Power differentials, difficulties establishing trust, and role confusion/conflict were all found to hinder the development of positive working relationships. Likewise, Brisset et al. (2013) found that power struggles and related role conflicts interfered with the development of interpreter-therapist trust.

Other than the above two studies, commentary in the literature on the interpreter-therapist relationship is based on the author's reflections on their own experiences in the field. These authors argue strongly that establishing a positive interpreter-therapist working alliance is crucial to successful interpreter-facilitated work. In her recommendations for working with interpreters, Lee (1997) asserts that "Clinicians must build a relationship of trust with the interpreter" (p.

487). Others go so far as to suggest that the interpreter-therapist relationship be the primary alliance in the therapy. According to Hamerdinger and Karlin (2003), effective integration of interpreters into treatment requires that the alliance between interpreter and therapist is strong and prioritized. They state, "Counselors and interpreters need to view themselves as a seamless team…it is critical that the [primary] alliance be between the interpreter and the clinician," rather than between either of the providers and the patient (p. 4-5). They also emphasize that this type of team-oriented alliance cannot be developed in the context of an approach that treats the interpreter as an instrument or non-person. They assert, "This means the therapist needs to see the interpreter as a colleague rather than a machine" (p. 4). Likewise, Tribe and Thompson (2009a) advocate for "building a fixed alliance in advance" between therapist and interpreter, in which "the clinician and the interpreter are slightly closer to one another than they are to the client, and can share their observations of the work and support one another" (p. 19). They suggest that joint supervision for interpreter and therapist may help in managing splitting and nurturing cohesion.

Therapeutic triads.

In both of their 2009 papers on their experiences in interpreter-facilitated therapy, Tribe and Thompson describe the shift from the dyadic to triadic therapy as an opportunity, rather than an obstacle. They describe an approach that actively and intentionally makes use of the therapeutic triad to *enhance* the process of healing. Their reflections on their work suggest that a great deal is to be gained through "embracing the contribution that an interpreter can make to the therapeutic process" (2009a, p. 17). They discuss interpreter-facilitated therapy as a unique transitional space offering an opportunity for the exploration and co-creation of culture and

meaning between therapy participants. They describe the reflections, reactions, and personhood of the interpreter as potential sources of rich clinical information. Furthermore, they note that the containment, safety, and potency of the therapeutic space can be increased by the therapeutic triad. For example, of interpreter-facilitated therapy with female survivors of sexual violence they stated, "The three-way relationship becomes a collective of women, with some commonality of experience, allowing the witnessing of traumatic experience to work with much greater effect" (2009b, p. 19). Not surprisingly, they emphasize the importance of nurturing the three-way alliance, stating, "What is crucial in this work is building a healthy three-way relationship… the interpreter is an integral part of a three-way alliance" (p. 18).

Miller et al. (2005) also reported that interpreters' emotional reactions may contribute to exploration and processing in session, rather than disrupt the therapy process.   They too highlighted the triadic nature of the therapeutic relationship, stating "the interpreter is an important witness to the client's experience, and the gradual unfolding of the client's story reflects a growing sense of trust not only between client and therapist but also between client and interpreter" (p. 30). Likewise, they highlighted the importance of maintaining interpreter consistency to the preservation of the three-way alliance.

Limitations in Current Research

There is a paucity of research on interpreter-facilitated psychotherapy. Most of the existing literature consists of clinical opinions and anecdotes offered by practitioners reflecting on their own professional experiences. There have been very few systematic studies related to working with interpreters in psychotherapy. Furthermore, existing research focuses primarily on challenges and difficulties related to interpreter factors, such as their lack of adequate training,

frequency of mistranslations, tendency to overstep role boundaries, etc. Alternately, a review of the literature found no research specifically focusing on therapist factors and how they affect the process of integrating interpreters into psychotherapy. Furthermore, while the literature describes a number of different models for working with interpreters, there is minimal research on the effectiveness and/or relevance of these different models. This study was undertaken to explore the interpreter-facilitated psychotherapy process from the perspective of experienced therapists, with a particular focus on the therapist's role in the process and how therapist factors influence interpreter-facilitated work. The goal was to develop a more comprehensive understanding of the dynamics related to interpreter-facilitated therapy and what therapists can do to improve their interpreter-facilitated work.

Chapter III

Methods

This study uses a qualitative research method to understand the experience of doctoral-level psychologists, experienced in working with foreign language interpreters in psychotherapy. The use of a qualitative method allowed for the collection of rich interview data to elucidate the experience of these therapists. This chapter discusses the use of qualitative methodology and describes in detail the characteristics of the study participants, the interview questions, and the data-analysis procedure.

Qualitative Approach

This study uses a qualitative approach to examine interpreter-facilitated psychotherapy from the perspective of therapists experienced in working with interpreters. There are several circumstances in which qualitative methodologies are preferable to quantitative methodologies. Morse and Richards (2007) outline three which are particularly relevant to this study. First, qualitative methods are desirable when there is little existing research on a topic or when research is limited due to being biased (Morse & Richards, 2007). When there is no clear hypothesis regarding what the researcher will find, using a qualitative methodology allows for the discovery of potential research questions within the data. Likewise, when the current understanding of a topic is incomplete or biased, qualitative methods create space for the researcher to consider the topic anew and to generate novel insights. Second, qualitative methods are preferable to quantitative methods when the goal is to make sense of information that is complex and nuanced (Morse & Richards, 2007). Qualitative methods allow a researcher to manage and derive meaning from data while preserving the complexity of the topic being

explored. Third, if trying to make sense of participants' experiences and the meaning they attach to these experiences, and if trying to understand participants' perceptions in a detailed manner, a qualitative approach is necessary to allow for the complexity of the data to be illustrated (Morse & Richards, 2007).

The current exploratory study meets each of these criteria. There is extremely limited research on the use of foreign languages interpreters in psychotherapy. What research does exist focuses primarily on interpreter factors (such as the impact of an interpreter's level of training on their accuracy of interpretation, the types of errors made by interpreters, and how inaccuracy and errors affect clinician diagnosis). There has been virtually no systematic examination of therapist factors in interpreter-facilitated psychotherapy. In addition to the shortage of research in this area, there is some indication that the current understanding of integrating interpreters into psychotherapy may be biased. The limited number of studies that have examined therapist factors in interpreter-facilitated treatment focus on their experiences working with interpreters and reflect that it is extremely common (though not universal) for clinicians to have negative reactions to integrating interpreters into therapy. This, together with the focus in the existing research on interpreter factors, suggests that there may be a bias in the current understanding of this topic, such that there is an over-emphasis on interpreter-centered challenges. Thus, qualitative methods are preferable in this study, as they permit the topic to be approached in an open manner that allows for the generation of new perspectives, questions, and information.

Qualitative methods are also called for in this study because the interpreter-facilitated therapy process is extremely complex, as are the dynamics that arise in the triadic therapy relationship. Using a qualitative method is ideal for preserving the complexity and richness of the data that should arise from an examination of this nuanced topic. Finally, this study seeks to

understand and make sense of therapists' experiences conducting interpreter-facilitated therapy in order to generate new and more comprehensive ways of understanding the dynamics involved in these encounters as well as the ways in which the therapist impacts these dynamics. Qualitative methods are necessary to gain a detailed understanding of participants' experiences and to make sense of them and the meaning participants attach to them.

The Long Interview Methodology

This study employed a specific qualitative method described by McCracken (1988) called the long interview methodology. The long interview methodology combines Grounded Theory and Ethnography (1988), allowing for a rich, in-depth consideration of complex data. Ethnography traditionally provides a means for exploring cultures, defined here as the "beliefs, values, and behaviors of cohesive groups of people" (Morse & Richards, 2007, p. 53). Though originally used to explore cultures based in nationalities or ethnicities, more recently, researchers have used ethnographic methods to explore subcultural units, including loosely connected groups of people like those with a particular occupation. This study examines the culture of psychotherapists who work with interpreters, within the larger context of the culture of the psychology field in general. Grounded theory is a qualitative methodology that is used to explore the way reality is socially constructed and evolves over time. It is particularly well-suited to studies in which to goal is to generate new information and build hypotheses from that new information, rather than to test or evaluate pre-existing hypotheses. In grounded theory, "the assumption is that through detailed exploration, with theoretical sensitivity, the researcher can construct theory *grounded in* the data" (Morse & Richards, 2007,

p. 59). Given that the field of psychology lacks a deep understanding of the process of integrating interpreters into psychotherapy and how therapist factors influence this process, using the long interview method allowed the researcher to delve into therapists' thoughts, feelings, and experiences regarding their interpreter-facilitated work, and to understand them in a larger contextual framework, without losing the nuance of therapists' subjective experiences.

A key element of McCracken's long interview method is the researcher's use of "self as instrument" (McCracken, 1988, p. 19). Essentially, this involves the researcher drawing on his or her own experiences to inform the study, particularly in terms of the development of areas of inquiry. From this perspective, it is actually beneficial to the study for the researcher to be a part of the culture under study. According to McCracken, "... deep and long-lived familiarity with the culture under study has, potentially, the grave effect of dulling the investigator's powers of observation and analysis. But it also has the advantage of giving the investigator an extraordinarily intimate acquaintance with the object of study...It is by drawing on their understanding of how they themselves see and experience the world that they can supplement and interpret the data they generate in the long interview" (p. 11-32). This was an important aspect of the process in this study, as the principal investigator is a doctoral student in clinical psychology, with more than two years of experience integrating foreign language interpreters into psychological assessment and treatment. In fact, this experience and its challenges were the impetus for the development of the current research study. As such, it was particularly important that the primary investigator cultivate an awareness of her feelings, experiences, associations, and thoughts related to interpreter-facilitated therapy when approaching the data.

McCracken's long interview methodology follows a four-step process of inquiry. The first step is an exhaustive review of the literature, which allows the investigator to define

research questions and assess existing knowledge. During this process, it is important for the investigator to maintain skepticism and search out the "conscious and unconscious assumptions" in the existing research (McCracken, 1988, p. 31). In addition, the literature review serves two main purposes. First, through becoming familiar with the literature, the researcher develops a set of expectations, and so heightens her capacity to be surprised by any data arising in her own study that defies these expectations. Second, the literature review aids in the construction of the study's interview questions.

The second step in McCracken's long interview methodology is called the "Review of Cultural Categories." It is at this point that the researcher truly begins to "sharpen" herself for use as an instrument in the research process. She seeks to develop a detailed and systematic appreciation of her experience with the topic under investigation. According to McCracken (1988), to do this "the investigator must inventory and examine the associations, incidents, and assumptions that surround the topic in his or her mind" (p. 32). Consideration of the researchers experience allows for identification of aspects of the topic that have not been considered by the literature, and which can inform the questionnaire. Furthermore, this step seeks to engage the investigator in both familiarization and defamiliarization with his or her existing world view. This combination allows the investigator to listen for familiar themes in the study data, and at the same time to maintain a necessary awareness of and distance from their own assumptions. As noted above, this was an important aspect of the process in this study as the principal investigator is of the cultural group being studied.

The third stage of McCracken's long interview methodology involves constructing the semi-structured interview questionnaire (Appendix C), selecting study participants, and conducting the semi-structured interviews. McCracken provides numerous guidelines for

designing a questionnaire that allows for the generation of new and unbiased data relating to the topic under study. First, the interview should cover the same areas of information in the same order with each participant. Second, it is essential that the interview be crafted so that the questions and prompts are not leading. In particular, because the investigator is part of the instrument used, they must be careful to manufacture the necessary distance between themselves and the study participants. Third, the semi-structured nature of the interview should establish "channels for the direction and scope of discourse," which serve to contain the potentially "chaotic" outpouring of information that a purely open-ended interview might generate (McCracken, 1988, p. 24-25).

In order to establish focus and to ease participants slowly into more personal topics, the interview should open with a standard set of biographical questions. Following these, the interview consists of non-directive, "grand-tour" questions and prompts, both of which are designed to encourage participants to "tell their own story on their own terms" (McCracken, 1988, p. 34-35) while remaining generally on-topic. For the entirety of the interview, the investigator should "keep as 'low' and unobtrusive a profile as possible (McCracken, 1988, p. 34).

Data Analysis

The fourth and final stage of the long interview process is the analysis of the data collected. The purpose of the analysis is to develop common themes among therapists experienced at providing therapy with the use of a foreign language interpreter. The analysis is conducted in five stages, moving gradually from examining fine details to observing general themes (McCracken, 1988). After the interviews are recorded and transcribed verbatim, the

investigator analyzes the transcript data. The first stage involves looking at each "utterance" without examining its relationship to other parts of the interview (McCracken, 1988, p. 42). In the second stage, each utterance is used as a new lens through which the transcript is scanned for similarities, contradictions, and relationships. The utterances are examined in relation to each other, to expectations developed through the review of literature, and to templates elaborated in the cultural review. In the third phase, the observations are considered in the context of their interconnectedness within the transcript and with existing literature; patterns begin to emerge. The fourth stage is a "time of judgment" in which observations are "harvested and winnowed" to derive a core set of general themes (McCracken, 1988, p. 46). Instances of redundancy are reorganized or eliminated. Themes are then organized hierarchically such that one or two are designated to be chief points under which other themes can be subsumed. Some themes must be relinquished and explored no further during analysis. It is important at this stage to observe whether any of the themes are in contradiction. Lastly, the fifth stage requires that the themes found within interviews in stage four be reviewed in light of each other. "It is time to take the themes from each interview and see how these can be brought together into theses," (McCracken, 1988, p. 46). Once the final themes are identified they become analytic categories and can be unified into a thesis and presented in the results section.

This study attempted to understand the process of interpreter-facilitated psychotherapy from the perspective of experienced therapists, with a particular focus on the impact of therapist factors on the process. It was expected that these therapists would describe varying levels of training and systemic support regarding their interpreter-facilitated work, as well as a variety of feelings and reactions to their interpreter-facilitated work. The study proposed to explore five major research questions relevant to integrating interpreters into psychotherapy:

1) How do therapists conceptualize interpreter-facilitated psychotherapy in terms of the interpreter's role, their relationship with the interpreter, and the interpreter's relationship with the patient?

2) To what extent do therapists acknowledge and engage with interpreters' presence in interpreter-facilitated psychotherapy?

3) What emotions do therapists experience in reaction to working with interpreters and to what extent do they reflect on and process these reactions?

4) According to therapists experienced in interpreter-facilitated psychotherapy, what should therapist training on working with interpreters entail?

5) Aside from interpreter factors, what challenges/obstacles arise in interpreter-facilitated psychotherapy?

Participants

Selection criteria.

The inclusion criteria for this study were that therapists possess a doctoral degree in psychology (Ph.D., Psy.D., or Ed.D.) and have conducted interpreter- facilitated psychotherapy with at least 3 separate clients, for no fewer than 4 sessions each. Interpreter-facilitated group psychotherapy was included in assessments of participant experience, with each group being considered as one patient. Though numerous study participants had experience in interpreter-facilitated psychotherapy, all therapists included in the study met the inclusion criteria with individual therapy experience alone. One therapist interviewed was eliminated from the study because he did not meet inclusion criteria in terms of experience in interpreter-facilitated

psychotherapy, though he had considerable experience in interpreter-facilitated psychological evaluation.

Recruitment.

Study participants were recruited using a network approach through the Graduate School of Applied and Professional Psychology (GSAPP) and through professional agencies involved in providing therapy to patients with limited English proficiency (LEP). These agencies included the Bellevue/NYU Program for Survivors of Torture, The International Institute of New Jersey, and Voices of Love. Emails were sent to various appropriate contacts in these agencies. A call for research participants was placed on multiple listservs, including Div56, MPA, and HealTorture. Some participants were recruited through other participants who were asked to forward information about the study.

Demographics.

Thirteen subjects were enrolled in the study. Two subjects were eliminated following their interview: one, due to failure to meet inclusion criteria in terms of experience in interpreter-facilitated psychotherapy, and the other due to technical difficulties which resulted in the loss of his taped interview prior to its transcription. Demographic characteristics of the study participants can be found in the Table 1 below.

Table 1

Demographic characteristics of study participants

Study Name	Gender	Age	Race	Degree	Yrs as Therp.	Yrs w/ Intp.	Estimated # Cases treated w/ Interpreter	Employment Setting(s)
Emily	F	43	Caucasian	PhD	5	2	8-10	CMHC & refugee outpatient clinic
Leah	F	43	Caucasian	PsyD	8	<1	50	long term skilled nursing facility
Eleanor	F	64	Caucasian	PhD	23	18	>100	private practice, torture treatment center
Marilyn	F	60	Caucasian	PhD	30	17	150-200	nonprofit outpatient clinic & refugee outpatient clinic
Laura	F	59	Caucasian	PsyD	26	25	>100	torture treatment center
Patricia	F	51	Biracial	PsyD	22	20	100	international non-profit
Rebecca	F	54	Caucasian	PsyD	12	9	200-250	CMHC & refugee outpatient clinic
Nicole	F	36	Caucasian	PhD	4	3	6	private practice
Ama	F	46	African American	PhD	20	8	6-7	Torture treatment clinic in a public hospital
Ines	F	39	African American	PhD	12	2.5	11	Torture treatment clinic in a public hospital
Paul	M	39	Caucasian	PhD	>1	>1	35	nonprofit mental health organization & department of corrections

Measures

Two collection methods were used to obtain data from participants. The first was a demographics questionnaire (see Appendix B), which was read to participants by the principal investigator. This questionnaire asked about basic participant information, including age, gender, type of doctoral degree, and employment setting. To roughly quantify how much relevant experience participants had, they were asked how many years of experience they had providing psychotherapy, how many years of experience they had working with interpreters, and the approximate number of interpreter-facilitated psychotherapy cases they had treated.

Next, each participant engaged in a semi-structured interview (see Appendix C), which was developed and administered by the principal investigator. This interview was comprised of open-ended questions about therapists' thoughts, feelings, and experiences regarding integrating

interpreters into their psychotherapy work, with particular attention to role conceptualization, relational process and dynamics, and therapist-specific factors. Questions were designed to meet the definition of McCracken's grand-tour queries (McCracken, 1988).

Procedure

Interviews were conducted in person, by phone, or via Skype™. All interviews were conducted in private locations. In-person interviews were conducted in participants' offices. Phone and Skype interviews were conducted in a combination of private offices and homes. First, participants read and signed an informed consent (see Appendix A). In the case of remote interviews, this consent was signed and returned to the principal investigator via mail prior to the scheduled interview. Any questions regarding the study and/or the consent form were addressed prior to beginning the interview. Participants were provided with a copy of the executed consent form for their own records. Second, participants answered a series of structured demographic questions (see Appendix B), which included biographical information, educational information, and information about the extent of their relevant experience. These demographic questions took about three minutes to complete. Third, participants were interviewed with a semi-structured interview made up of questions regarding their thoughts, feelings, and experiences regarding working with interpreters in psychotherapy (see Appendix C). Interviews were audio taped to contribute to the authenticity of the study. Interviews took, on average, approximately 90 minutes, with the shortest interview being 30 minutes and the longest lasting 130 minutes. Participants were given the option to withdraw at any point in the study, however all eleven participants completed the study protocol. No adverse effects attributable to the study were reported by any participant during or after the interview.

Each participant was assigned a case number, which was used to identify response materials. No identifying information was attached to the transcripts or audio-recordings of the interviews. The principal investigator transcribed all interviews. All identifying information was removed from the transcripts. Consent forms were kept in a locked filing cabinet separate from the collected interview data. All audio recordings, interview transcripts, and other data collected from study participants will be maintained in confidence by the principal investigator in a locked filing cabinet for three years after completion of the study. The principal investigator will destroy all research material after three years.

Chapter IV

Results

The Importance of Relationships in Interpreter-Facilitated Psychotherapy

 The interpreter-therapist relationship.

 Ninety-one percent (91%) of the eleven therapists interviewed for this study emphasized the importance of the interpreter-therapist relationship in interpreter-facilitated psychotherapy. Two study participants went so far as to characterize this relationship as a "primary" relationship in the therapy as vital, if not more so, than the relationship between the therapist and patient. Leah, for example, asserted the significance of the interpreter-therapist relationship when asked what to include in a training program on working with interpreters. She stated,

> The thing that I would think of first is just creating a relationship with the [interpreter] and having the partnership be what's primary… your relationship with that person is as key as your relationship with the patient – in many ways more so.

 Likewise, all participants who spoke about the interpreter-therapist relationship asserted that having a positive relationship with interpreters was a key element of the interpreter-facilitated therapies which they considered the most successful. When asked what stood out about the interpreter-facilitated therapies that she felt were the most successful, Ama replied, "A good relationship with the interpreter – good communication and a good strong alliance with the interpreter. You really want to have strong alliances with your interpreters."

 Emily asserted the importance of the interpreter-therapist relationship through describing the frustration she feels when required to work with an interpreter in the absence of an on-going relationship.   She stated,

> Having a relationship with the interpreter can make such a huge difference… [When] it's just a one-time deal – somebody you don't know – it can be really frustrating… [I need] to get all this really delicate, painful, traumatic information; and it's so frustrating, when I don't have a team member. I want one of my [regular] people in the room with me.

Trust in the interpreter-therapist relationship.

Sixty-four percent (64%) of therapists interviewed specifically noted the importance of trust in interpreter-therapist relationships. Rebecca stated, "There is something nice about being part of a team and working with the [interpreter], especially when you have a long-term relationship with a lot of trust."

A number of therapists asserted that trust in the interpreter-therapist relationship is crucial because of the degree to which therapists must rely on their interpreters. They pointed out that, because they can never know for sure what interpreters are saying to patients, being able to trust interpreters to accurately represent what they and their patients express is key. Similarly, study participants stated that they rely on interpreters' cultural knowledge to give context to patients' comments and behaviors, and so need to be able to trust the judgment of their interpreters and the accuracy of the information they offer. Laura reflected,

> It was really, really important that we developed trust. I think any therapist who works with an interpreter has to trust their interpreter. You have to trust that they convey the words you want to say. I remember working with a Vietnamese [interpreter] and she used to say to me, "You know [Doctor], I know that you're going to say a couple sentences, but I'm going to have to speak pages." It had to do with the Vietnamese culture of two women talking to a male… [so I had to trust] the cultural input from the interpreter and that what she was telling me was true.

Four therapists also indicated that building trusting relationships with interpreters improves interpreter-therapist communication. In particular, study participants spoke about an improved ability to work through conflicts and challenges collaboratively in the context of a trusting interpreter-therapist relationship. Emily stated,

> I think having a trusting and respecting collegial relationship between the two of us makes a huge difference. We can talk through things when they go well, but more importantly, when they don't go so well, we have enough of a relationship that we can try to puzzle it through together.

Rebecca echoed these sentiments, sharing,

> Working together for a long period of time and really understanding each other, and knowing how each other works, and being able to work through the conflicts, which inevitably come up from time to time – knowing that that is okay because we trust each other… [that is when] the work is most effective.

Similarly, some participants asserted that a trusting interpreter-therapist relationship increases their ability to effectively offer feedback to interpreters. They described benefits in terms of the therapist's comfort offering feedback and the interpreter's openness to receiving feedback. When elaborating on the benefits of building trust with her interpreters, Emily reflected,

> In the beginning I was worried that I didn't want to offend him or her, so it took some time to build up that relationship so we really could work through things, so I could say, "You know what? Next time would you be willing to try this a little bit differently?"

Elaborating on how a trusting interpreter-therapist relationship improves the interpreter's ability to receive feedback, Paul reflected,

> One of the benefits of working with someone over time is definitely that we develop a relationship. [The interpreter] develops a level of trust with me, so he doesn't think I'm criticizing [when I give him feedback], but [sees] I'm actually helping him be more effective.

The interpreter-patient relationship.

Seventy-three percent (73%) of therapists interviewed spoke about the importance of the relationship that develops between the interpreter and patient in interpreter-facilitated psychotherapy. Participants expressed feeling that a positive interpreter-patient relationship benefits the therapy. Rebecca stated,

> When you have an interpreter in the room, there is another person in the room – there is another relationship that is developing. And, unlike some models, we *encourage* that… We expect the client to establish a level of trust and relationship with the interpreter. I really believe that enhances the therapeutic process.

Nicole also emphasized the therapeutic benefit of patients developing positive relationships with their interpreters, and then offered an anecdote in which she attributed increased progress in a patient's therapy to an improved interpreter-patient relationship. She shared,

> The relationship between the client and the interpreter is crucial… If that relationship is successful, [it's] really good for the client – really therapeutic – and it facilitates the therapy process… I have a patient who I've been working with for three years…now we are on our third interpreter… I can definitely see the difference that a successful, productive relationship between the client and interpreter makes. [Work with] this last interpreter has been the most successful and I think that's primarily because my client was able to relate very well and feel very comfortable with this interpreter.

Trust in the interpreter-patient relationship.

Fifty-five percent (55%) of therapists interviewed spoke about the importance of trust in interpreter-patient relationships. Marilyn stated, "You've got to make sure that the patient is not only comfortable with you but that there's also safety and trust… established with the interpreter."

Likewise, as noted above, Rebecca emphasized the value of trust in the interpreter-patient relationship, stating, "We expect the client to establish a level of trust and relationship with the interpreter. I really believe that that enhances the therapeutic process."

A number of therapists highlighted the importance of trust in the interpreter-patient relationship specifically with regard to confidentiality. They noted that it is not uncommon for interpreters to come from the same small ethnic communities as patients, and that patients may fear that their interpreters will repeat private patient information to fellow community members. When asked what challenges arise for patients regarding the presence of an interpreter, Eleanor stated,

The lack of trust is a big one. Terror of the interpreter not keeping confidentiality is a big one… the fear of somebody in the community knowing… You're asking them to trust, not only you, but also this other person who may be from their community.

Ines echoed these statements, sharing, "I've had situations where the interpreter triggered all [the patient's] traumatic stuff around the safety of people and who they can trust. [They worry] 'Where's this information going?' and 'Who else is going to find out about it?'"

Minimizing the interpreter-patient relationship.

Though the majority of therapists interviewed felt that a positive interpreter-patient relationship is beneficial to therapy, two participants also made statements suggesting a desire to minimize – or avoid altogether – the development of a relationship between the patient and the interpreter. Patricia asserted that when interpreters attempt to connect with patients or build rapport with them, it disrupts the therapeutic process. She stated,

What was good about my interpreter in Uzbekistan is that he had no desire to be a counselor – as a counselor, you want to gain rapport, you want to connect, you want to make eye contact. [However,] an interpreter really has to bow out of the picture and just facilitate communication… if I have to constantly be reminding them to not engage with the patient… and to stay out of the session… that becomes really frustrating for me because I see [that] then the therapeutic process stops… When I am training interpreters I am always saying, "If the patient is interacting with you, we are not successfully doing this."

Marilyn too expressed that she prefers to minimize an interpreter's engagement with patients. She stated,

I really want the interpreter to be somebody that's quiet, nonintrusive, and is really giving me word for word [interpreting]… It takes some skill to make sure that the conversation is occurring between the therapist and the client and that the interpreter is there merely to give voice to the words, but [is] not a part of therapy.

The therapeutic triad.

Two therapists described a more communal conceptualization of interpreter-facilitated psychotherapy. They spoke about "developing a relationship as a trio" and co-creating a healing space within the "therapeutic triad." These participants asserted that the relational community itself – formed between patient, therapist, and interpreter – is what is healing for patients. When asked what characterized her most successful interpreter-facilitated therapies, Eleanor responded, "It's the healing atmosphere that you can have if the interpreter and the client and you will develop a relationship. You develop a relationship as a trio. I think that is really the most powerful thing." She went on to describe a case in which she felt a patient gained more as part of a therapeutic triad than she would have in a traditional dyadic therapy relationship. She reported,

> I remember working with another African client who was so distressed and depressed, and we were desperate for how to help her through that day and the next week. I had taken this yoga class, where there was a pose called the warrior woman pose. At one point I was telling this woman that she had been so strong to survive her torture, that she was like a warrior, [to be] going out into the world still. I stood up, and I showed her this pose, and my interpreter got into this pose, and the client got into it. And we stood in this circle – this triad of women in the warrior pose – and it was a transformative moment. The client just really, really liked that and she reported in the next weeks, whenever she was upset, she would go into the warrior pose. And that was an example of something that happened with the interpreter, where three of us offered much more than just the therapeutic dyad [could offer]. We were a group. We were a healing group.

Laura too, emphasized the healing potential of the "therapeutic triad." She described the positive effects of therapists and interpreters modeling healthy, trusting relationships for patients, and the reparative power of patients experiencing trust, openness, and respect within the triadic relationship. Laura shared,

> If the client meets you and the interpreter and has that sense of your trust and respect for each other…that is really such a potent component that you are bringing into the therapeutic relationship. That's what you want to achieve with the client. If you already have it with someone and you're modeling it – openness, trust, respect – it helps… You

[and the interpreter] develop a relationship, you develop trust, you develop respect, you develop communication, and then that you just include the client into that setting of relational approach… and that's what's been hurt, right, that's what's been injured in the trauma experience, so it becomes a way to have an in vivo experience of repairing these damaged aspects of relationships – with trust, with respect, with communication.

Maintaining Interpreter Consistency

All but one of the therapists interviewed (91%) reported that they prefer to use the same interpreter throughout a treatment. Laura spoke particularly resolutely about interpreter consistency, framing it not as a preference, but as a necessity. She explained that in the torture treatment program where she is clinical director, the clinical staff will only work with interpreters who make a commitment for the duration of treatment. She stated,

It's required… We ask that the interpreter make a commitment to see the client through the intake process, which could be two to five meetings. Then, once someone decides if they want to engage in therapy, we ask the interpreter to make a commitment to see the client through their therapeutic process. It's just part of what we do.

Interpreter consistency facilitates therapeutic relationships.

When invited to elaborate on their preference for interpreter consistency, participants highlighted the relational nature of therapy. One hundred percent (100%) of therapists interviewed noted that working with the same interpreter over time facilitates the development of positive relationships between therapy participants. More specifically, many therapists asserted that interpreter consistency is integral to the development and maintenance of trust and safety within the therapy. Interestingly, participants often emphasized the importance of consistency by speaking about the negative impact of the alternative – interpreter inconsistency. Emily stated,

If it's a different interpreter each time, then it's just bad. That's just bad. If it's the same interpreter, [it's] somebody I get to know and the client gets to know… [But with a different interpreter each time] it's much more just interpretation… it doesn't feel very relational. It feels like a barrier as opposed to an aid.

Interpreter-patient relationships.

Fifty-five percent (55%) of therapists interviewed spoke about the importance of interpreter consistency to the development of relationships, trust, and safety between patients and interpreters. When asked how interpreter consistency affects treatment, Marilyn stated, "It's good. I think it's a very good thing, because trust is always important in therapy… [and it needs to be] established with the interpreter as well."

Again, study participants tended to highlight the benefits of interpreter consistency by noting the damaging effects of its absence. Four therapists described switching interpreters as detrimental to the therapeutic process, labeling it "disruptive," "traumatizing," and "harmful." Eleanor emphasized the relational benefit of interpreter consistency when describing the strain caused by bringing a "stranger" into session. She stated,

> I think it's really very difficult, if you have to switch interpreters. It's like switching therapists almost. It matters that you have a stranger in the room… Because if you're telling your trauma story, and it's very long, which they always are, very complex, and you get down the first third of the road and you're going into the deeper trauma and you have a different interpreter for that day - that's really hard on the client.

In addition to these general comments, two therapists offered anecdotes in which patients clearly expressed a preference for interpreter consistency, even in the face of some difficulty. Laura described a female patient who struggled to speak about her history of sexual assault in the presence of her male interpreter. Despite this, the patient declined the offer to switch to a female interpreter, stating, "No, I don't want to change [interpreters]… I want to continue our work with the male interpreter because we have a good working relationship… we'll talk about [the rape] in time." Ines also described working with a patient who strongly preferred interpreter consistency. She shared,

> We have an interpreter that's worked with us now for over a year, and she moved from being a face-to-face interpreter to being on the phone, in part because [the patient] basically refused to work with anybody else… It was a bit of a pain. Her availability was

not as broad as others, so I was like, "*really*?" But we did it because at that time I wouldn't have gotten anywhere with him had I said, "Now you're just going to use a different phone interpreter every time." It just would've been more traumatizing and harmful.

Interpreter-therapist relationships.

In addition to the positive impact of interpreter consistency on interpreter-patient relationships, eighty-two percent (82%) of therapists interviewed described interpreter consistency as beneficial to the interpreter-therapist working relationship. Nicole stated, "I think [interpreter consistency] helps the treatment very much. We have this relationship happening already. I don't need to start all over again with a brand-new person." Leah echoed these sentiments and went on to comment on the collaborative nature of the interpreter-therapist relationship within the context of consistency. She reflected,

> I would say the biggest difference [resulting from interpreter consistency] is that I have a growing relationship with [the interpreter]. We talk about the patients when they're not there. We will constantly debrief and I'm really interested in what she has to say, and she's learning from me.

A number of therapists also pointed out that interpreter consistency allows therapy participants to learn how to work together effectively. Nicole stated,

> I think [interpreter consistency] helps the treatment… [The interpreter] knows my style of work. They know how I talk, how fast I talk. They know generally what type of format of therapy I'm using, so they know my style. I know their style of interpreting as well. That's very positive to the therapy process.

Additionally, Paul noted that interpreter consistency can provide opportunities for therapists to train the interpreters with whom they work. He shared,

> The benefit of [interpreter consistency] is that I could train him… being able to work with him over time, I was able to give him feedback and shape his behavior so that he could be much, much more effective as an interpreter.

Exceptions: the benefits of switching interpreters.

Though study participants overwhelmingly expressed a preference for interpreter consistency, there were some notable exceptions. Two participants spoke about the therapeutic value of patients sharing their stories with new people. When asked if she prefers working with the same interpreter throughout a treatment, Ines responded, "It depends on what is therapeutically indicated for the client." Though consistency was her "default" with on-going therapy clients, Ines gave an example of a client whom she felt would benefit from switching interpreters each session. She explained,

> I have [a patient] now where I think it's probably getting to be more therapeutically indicated for him to work with a different interpreter every session, because he is so afraid of it. In some ways it's sort of exposure therapy. He has a very hard time with strangers, and yet, he has an asylum interview coming up where he has got to tell his story to some official that he doesn't know. So, to the degree that his fear of the unknown person is hindering him in something that's incredibly important, I think it may be [therapeutically indicated for him to switch interpreters each session].

Similarly, though Rebecca expressed a clear preference for interpreter consistency, she also pointed out that working with an occasional substitute interpreter can be beneficial for patients. Like Ines, she spoke about the value of having patients tell their story to a new person. She stated,

> If I see a patient with [a certain regular interpreter], and she calls in sick, I'll see them with any of the other interpreters who are here, but it's clearly a substitution. Sometimes, that is a benefit, especially if the substitute hasn't met with a particular client before, because the client has a new opportunity to talk about themselves and to tell their story... If it was [the regular interpreter], who knows the story, they wouldn't tell it again, but [with a substitute] they might tell it again and it might be therapeutic for them to tell it to a new person.

Conceptualization of the Role of Interpreter

    Facilitating communication.

Not surprisingly, one hundred percent (100%) of therapists interviewed asserted that the interpreter's role is, at least in part, to facilitate communication between the therapist and patient through language translation. A number of participants specifically labeled this aspect of the interpreter's role as "facilitating communication." Emily, for example, spoke about the "communication piece" of the interpreter's role, stating that the interpreter is a "person who is helping us – the client and I – [through] facilitating our communication." Similarly, Ama described the interpreter as "someone who facilitates the transmission of information [between the patient and the therapist]." Rebecca stated that part of the interpreter's role is "to translate" the "words" of the therapist and patient.

Furthermore, forty-five percent (45%) of therapists interviewed indicated that the primary task of the interpreter is to serve as an extension of "the voice" of the therapist or patient. Eleanor stated, "I think the interpreter's role is, number one, to be the voice of both the therapist and client." Similarly, Patricia asserted, "[Interpreters] have a couple of different roles, actually. The first is to be my voice and to be a neutral facilitator of my voice and the patient's."

It is worth noting that all of the study participants who characterized the interpreter as an extension of the patient's and/or the therapist's voice also acknowledged, to varying degrees, that the interpreter's role goes beyond merely being this extension. Leah, for example, highlighted her conceptualization of the interpreter as an extension of the therapist; however, she also acknowledged the cultural broker aspect of the interpreter's role and the fact that the interpreter has a voice of her own. She stated,

> I think about her as an extension of me in one way, and also as someone who brings a
> unique knowledge of the population that she's working with... She's just an extension of

my voice in many ways. Even though she brings her own voice, ultimately she is trying to convey my intention.

Acting as cultural brokers.

One hundred percent (100%) of therapists interviewed defined the role of the interpreter, at least in part, as one of cultural broker or educator. This involved informing the therapist about a patient's culture and placing a patient's symptoms, behavior, and experiences into cultural context. Patricia stated, "I also see the interpreter as what I call a 'cultural broker.' They interpret the cultural [implications of] things to me that I may not understand, not just the literal meanings of words." Ama too highlighted the benefit of interpreter provision of cultural information and context, reporting that,

> The interpreter… can also facilitate cultural understanding and awareness, and sometimes [provide] historical information. For example, when I was working with somebody from Albania, there were things I didn't know about their culture, about their town. Because the interpreter was from there, she gave me perspective. She said, "This is a very small town, in a very rural area," which shifted how I was able to understand the individual's functioning.

In addition to contextualizing information presented by patients, three therapists also described relying on interpreters for input regarding some of their own culturally-based behaviors. They described the role of the interpreter as including educating therapists about certain norms in patients' cultures (such as common greeting rituals or expectations around title formality) that therapists might adopt in order to make a patient more comfortable in session. Emily stated, "I find it crucial to have the interpreter help me bridge the cultural issues [with patients]. Like… How should I greet them? How should I not greet them?" Likewise, Laura described the benefit of having her interpreter "prep" her on how she might adjust her behaviors when interacting with a patient from a different culture. She stated,

If [the interpreter] is from the culture, they can… prep me about eye contact, or how to address someone. I'm very casual and informal and I like it when people call me [Laura], but I'm also respectful that in some cultures, people want to see a *doctor*. And maybe they'll call me Dr. [Laura] instead of [Dr. Goldberg,], but [doctor] is not a title I use very often, so that kind of prepping is useful.

In addition to providing cultural context and education to therapists, four study participants described the interpreter's role as providing cultural education and context for patients. They spoke about the value of having an interpreter who understands both the culture of the country where the therapy is taking place and the "culture" of psychotherapy itself, and who use this understanding to make the therapist's interventions more accessible to patients. Rebecca, for example, stated,

Part of the interpreter's role is to translate and bridge culture, as well as words. They are critical in understanding the patient's worldview… If somebody brings up a cultural practice or ceremony [the interpreter] will explain, "In our culture we do such and such and such." It's the same [with normalizing American practices]… So hopefully you have got somebody who is really bicultural [with] a good understanding of mainstream American culture… And the good thing about having interpreters on staff, is that they get very familiar with what we are doing, how we are doing it, and how to explain it to people… There's no word in Khmer for "panic attack," or for lots of the symptoms that we talk about, so it means [the interpreter engages in] a lot of explaining concepts and giving examples that relate to rice farming, or water buffalo, or something… putting [therapy concepts] into the cultural context [for patients].

One respondent, however, clearly disagreed with this broader conceptualization of the interpreter's role. Ines specifically noted that she does *not* view educating patients on American culture or on the culture of psychotherapy as part of the interpreter's role. She stated,

Their role – with regards to me – is to help educate me about the cultural background [of the client]… Regarding the client, it's in some ways a parallel role, but I don't see the interpreter as an educator of the client as much as I do mostly a facilitator of the client's communication. I don't expect them to educate clients about American culture or about the therapeutic process.

Interpreters as bridges.

Four of the therapists interviewed invoked the image of a bridge when discussing their conceptualization of the interpreter's role. Leah, for example, emphasized the centrality of the interpreter in gaining access to patients with limited English proficiency (LEP). She stated, "I think about [the interpreter]… like a bridge… that person is the liaison, or connection, or bridge to the patient." The other study participants who invoked bridge imagery specifically described the interpreter as a bridge of language and culture. Rebecca described the interpreter's role as to "bridge the culture, as well as the words [of the therapist and patient]." Laura also spoke about the interpreter as a "bridge" of both language and culture. She went on to describe how the interpreter functions as a cultural bridge, holding and representing knowledge of both cultures – the culture of the patient's country of origin and the culture of the country where the therapy is taking place. Laura reflected, "That's why I prefer working with interpreters. You're doubling that connection of someone here [who can say], "I understand where you are now," and who [can also say], I understand where you came from. That's *very* potent."

Active relational engagement with patients.

Forty-five percent (45%) of therapists interviewed conceptualized the interpreter's role as an actively relational one, in which the interpreter provides emotional support and participates in emotional processing with patients. These participants felt that the interpreter's role includes being a supportive presence for patients as well as well as connecting with and responding to them, beyond merely repeating the therapist's words. They emphasized that interpreters' relational engagement with patients can be a valuable part of the patient's healing process. Leah, for example, described how grateful her patients are for the "holding" provided by the

interpreter. Laura too, highlighted the supportive nature of the interpreter's role, stating that

when working with interpreters, "there's more support in the room."

Eleanor emphasized the active relational engagement of the interpreter with the patient,

describing the interpreter's role as including "bearing witness" to the patient's experience,

"sharing" in the patient's feelings, and responding to the patient as a person separate from the

therapist. She stated,

> The interpreter and I present a kind of audience, bearing witness to the horrible trauma
> that most of my clients have been through. It can be very healing for the client to have
> more than one person hear their pain… and respond in a way that is helpful, as opposed
> to destructive… the therapist and the interpreter are sharing the feelings with the client…
> That contains the seeds of healing.

Likewise, Rebecca spoke about the interpreter's role as one in which the interpreter connects

with patients and responds to clinical material directly, in addition to communicating the

therapist's response. In fact, Rebecca explained that in the outpatient clinic where she works,

interpreters are considered such an active and integral part of therapy, that they are called "co-

counselors." She shared,

> The [interpreters] that we have on staff with us we call "co-counselors," because that is
> how we view them… They are empowered to ask follow-up questions, to follow up on a
> story a little bit on their own, to make sure that they understand it… I really believe that
> that enhances the therapeutic process, because [patients] are able to talk to somebody
> directly – to have that person respond to them with their body language, with their facial
> expression, with follow-up questions on their own, not just going through the therapist.

In addition to offering support and responding to the clinical material presented by

patients, two of the therapists interviewed stated that the interpreter's role may also involve

helping patients process their experiences through sharing similar experiences from their own

histories. Laura spoke about conducting therapy with an Iraqi patient, in which the interpreter's

disclosure of his own, similar, trauma history helped the patient feel less isolated and better

understood. She stated,

> The [Arabic] interpreter was from the [Iraqi] community. He had come earlier, in a different wave. He had his own trauma… that the interpreter shared his experiences, [even though they] happened at a different time period than the client's… there was some normalization [for the client]… there was this sense of, "I'm not only one this happened to. This person understands."

Rebecca also asserted that the interpreter's role may include sharing personal experiences. She offered an anecdote in which an interpreter's decision to disclose aspects of her own history helped a patient share more openly. Rebecca reflected,

> Sometimes [interpreters] will share their experiences. I have a client who [switched to working with a new interpreter after her old interpreter left] and it turned out that, during Khmer Rouge, they had been living in neighboring villages and gone through very similar experiences. When they discovered that, they just ended up talking with each other for most of the rest of the session… they were so engaged, and [the patient] opened up more and told more of her story than she ever had before, because she had that connection at a very human level. And in our model [of interpreter-facilitated psychotherapy] that's good – it's not only okay, it's good.

Active relational engagement with therapists.

Four of the five therapists who spoke about the interpreter's role as actively relational with regard to patients, also described the interpreter's role as one in which they provide emotional support to therapists and participate in therapists' emotional processing of clinical material. On top of the direct support interpreters provide to therapists, participants suggested that the interpreter's emotional support of patients is also a form of support for therapists – that through providing another source of emotional support for patients in session, interpreters decrease an emotional burden normally carried by the therapist alone. Laura expressed this perspective, and went on to note the emotional processing piece of the interpreter's role as well. She reflected,

> I actually miss working with interpreters if I'm doing [therapy with] an English-speaking client… I feel the absence of the other person in the room with me. It's harder with this severe level of trauma. I really respect the dimension an interpreter adds in terms of

support and holding… I'd much prefer to [have them there, even if I need to] help the interpreter process their emotional reaction, because in a way it helps me process mine.

Eleanor too emphasized the interpreter's role as a source of emotional support and an active part of emotional processing for the therapist. She asserted that working with interpreters can decrease therapists' vulnerability to vicarious trauma, stating,

It's helpful for [preventing] secondary trauma to have the therapy interpreter to debrief [with]. Sometimes after really bad sessions the interpreter and I would do a sand tray together to process the pain, and that could be really, really healing. When you have each other to debrief with, you can spread the pain across three shoulders instead of two.

Two therapists also specifically stated that the interpreter's active engagement in supporting them and processing sessions with them decreases their sense of aloneness. Emily shared,

I appreciate having somebody to chew over the session with afterwards. Because some of our sessions can be really difficult and painful, it's nice to have the support, both in the room and afterwards. Somebody else knows what's going on, so it doesn't feel so lonely.

Acting as partners and collaborators.

Forty-five percent (45%) of therapists interviewed conceptualized the interpreter as a partner or collaborator who works *with* them, rather than *for* them. Ama, for example, stated, "[The interpreter and the therapist] are actually working together with the client… We really need to think of them as partners."

Most of these participants also described actively working to establish a collaborative frame of therapy with their interpreters and seeking to minimize the potential power hierarchy. They describe how conceptualizing interpreters as partners means sharing power, control, and status with them in session. Laura described forming "therapeutic partnerships" with interpreters and patients in which "everybody's an expert." She stated, "We are creating more of an egalitarian system rather than an authoritarian, single-expert system... We are partners. We are

equals. We are in this together." Leah too described the interpreter as a partner and an equal, sharing,

> To me it's essential that there is a very limited power dynamic between us… not like she works *for* me, or she's doing me a favor, or she's *just* an interpreter and I'm the *doctor*. I really try to minimize that… We are partners. We are equals. We are each doing a job and, even though we have different training, it's all in service of the patient.

Similarly, Ines described her intentional efforts to shift from a hierarchal relationship with her interpreter to a more equal and collaborative one. When describing the theoretical frame within which she integrates interpreters into psychotherapy, she stated,

> It was very easy to be invited into a hierarchical sort of stance towards the interpreter. I'm really working to shift towards a more collaborative one. This is somebody that I am working *with*, to help me understand clients and to help clients understand me… Your interpreter is your collaborator. You're not their boss.

On top of describing the interpreter as a partner and speaking about the power included in this conceptualization of their role, four participants also noted that working with an interpreter as a *partner* inherently involves a "humbling" of the therapist role. These participants asserted that *sharing* power, control, and status naturally requires that therapists give up a certain amount of each of these things; that conceptualizing the interpreter as a partner inherently affects their conceptualization and experience of their role as therapist. Rebecca, for example, spoke about sharing power with the interpreter when "doing" therapy together, and reflected on how this requires the therapist "letting go" of some of her ego. She offered,

> [Working collaboratively with an interpreter] really changes the therapy from the therapist's perspective, because you have to let go of some of your ego in the relationship. You have to let go of this idea that you are the one doing this, because you're not. It is really the interpreter who is doing it, plus you… You have to give up your sense of being the [only] one with the relationship [to the patient].

Likewise, Eleanor spoke about how treating the interpreter as a partner compels the therapist to let go of some power, status, and control in the therapy, creating a more egalitarian therapeutic frame in general. She stated,

You have to give up a lot of control over the situation… It changes the whole idea of the therapist's power. It reduces the standpoint of the therapist being the person with the possession of the knowledge and the therapy client being the recipient of whatever great words the therapist might have to say. It changes [the therapy] back into more of a communal experience.

Interpreter Neutrality is a Myth

One hundred percent (100%) of therapists interviewed asserted that interpreters, as human beings, have personalities, emotions, and opinions that inherently affect their presence and how they convey the communications of therapists and patients. This theme was discussed in a number of different ways. Numerous participants directly asserted that because all verbal communication passes through the interpreter's consciousness, their personality, emotions, and opinions influence and potentially shift what is communicated. Nicole, for example, emphasized the impossibility of interpreter neutrality and the importance of maintaining awareness of the potential impact of interpreters' feelings. She stated,

> The interpreter is also a *person*. He's not just a computerized version of translation. The interpreter brings his or her own emotional reaction to interpretation, and it always needs to be taken into consideration. Some of those especially emotional reactions, you can feel them in the session; you can hear them in the translation… So it's very important, in my work, not to treat interpreters as just a completely neutral third person. That person is never neutral.

Paul also emphasized the limits of interpreter neutrality and the importance of being aware of how interpreters' individual personalities might influence the communications they relay. He reflected,

> [I] absolutely have to manage the personality of the interpreter, and take that into account, and see how that is affecting my message in my treatment and my care of my patient… [because] the messages are being changed and altered. Every time I say something, it is being changed.

Within the broad idea that the emotions and personalities of interpreters impact how they translate information, a few more specific themes arose. Numerous participants noted that when

an interpreter has a trauma history and is working with a trauma patient, this history and the

interpreter's related emotional experience may influence the interpretation process. Laura stated,

> If someone immigrated or came as a refugee 20 years ago and now is volunteering [as an interpreter] with a new wave of survivors from their country, they may have mixed feelings about that… emotional reactions… I mean, I've had interpreters start crying when they hear [a patient's story, and say] "It reminded me of what happened to me."

Furthermore, two study participants offered anecdotes in which interpreters with trauma histories

had such strong emotional reactions to the clinical material presented by patients that they

(temporarily) refused to interpret what had been said. Eleanor spoke about a Bosnian interpreter

who refused (until the following session) to translate a Bosnian patient's trauma story, in which

the patient's grandmother was raped. She stated,

> I don't know if it was the age of the grandmother or that [the interpreter's] own grandmother had been raped by the Bosnian Serbs, [but] the interpreter said, "That didn't happen. It did not happen." And he refused to interpret it and he denied it, because it was too close to his own experiences and his own family.

Laura shared a similar story. She offered,

> There have been times where whatever it is that was shared by a patient… was touching something in the interpreter that was too painful for them to address… I had one interpreter [refuse to interpret because]… he was afraid what [the patient had] just shared might have happened to his wife, and he didn't want it to be true. He wanted to distance himself from that possibility.

> Some participants noted that an interpreter's political beliefs can influence their presence

in session and how they deliver the statements of patients and therapists. Marilyn, for example,

spoke about how an interpreter's feelings about a patient's country of origin tainted her

translation of what the patient said. She offered,

> The client was from Iran and the interpreter had some very negative feelings about people from that country. And I couldn't use her after the first session, because… [of her] attitude. The ways that she would repeat what the client had said – there wasn't a match in affect or mood. It had an attitude to it.

Finally, two of therapists interviewed reported that an interpreter's opinion about a therapeutic intervention can influence how the interpreter delivers that intervention. Ama emphasized the importance of being attuned to such potential shifts in communication, stating,

> [I had one interpreter who] was, in ways, sabotaging. She would say, "Why did you do that? I don't know if that was such a good intervention to have made."… If you don't know the language, you don't know how that [opinion] is filtering the information in the communication. So, a real awareness for that kind of thing [is essential].

Therapist's Emotional Reactions to Working with Interpreters

Prevalence of mixed emotional reactions.

Seventy-three percent (73%) of therapists interviewed reported experiencing both positive and negative emotions in reaction to their work with interpreters. Alternately, one participant expressed only positive emotions and two expressed only negative emotions. Not surprisingly, most of those who reported experiencing both positive and negative emotions described having positive feelings when interpreter-facilitated therapy went smoothly and negative feelings when things were more challenging. Emily captured this dichotomy, stating,

> [I have] positive emotions when I feel supported. I feel angry when I have an interpreter who is not doing their job well [or] who is disrespectful… So there's some anger when things aren't going well. And then there's a sense of support and *peace,* actually, when it does go well – when I feel like I'm connecting and it's all gelling well.

Positive emotions.

Eighty-two percent (82%) of therapists interviewed reported experiencing positive emotions in relation to working with interpreters. The most common positive emotions described were joy, gratitude, camaraderie, and a feeling of relief due to being supported. Feelings of inspiration and pride were also described by a smaller number of participants.

Fifty-five percent (55%) of respondents spoke about experiencing feelings of joy in reaction to working with interpreters. In addition to the term "joy," they used words like "enjoyment," "excitement," "fun," and "peace" to describe their experiences. Leah, for example, described feeling "so pleased that someone else can participate" in the therapy process. And she later stated of her experience with her interpreter, "We have a lot of fun. We laugh a ridiculous amount." Nicole also described feelings of joy in relation to her interpreter-facilitated work, stating,

> There is lots of joy and excitement when I see that the work is happening – when I see that there are changes that are happening in the client…those are the situations [in my interpreter-facilitated therapies] which make me feel very joyful and very excited and very satisfied.

Fifty-five percent (55%) of therapists interviewed reported that working with interpreters elicits feelings of gratitude and appreciation. For example, when asked about her emotional reactions to working with interpreters, Laura offered, "Well, one is incredible appreciation of what they're doing. I appreciate the interpreters so much." Eleanor echoed this gratitude towards interpreters and appreciation for their role, stating, "Mostly, I feel lucky. I feel lucky to have somebody there to allow us to communicate when it's so important. It's really a life-giving act for an interpreter to interpret a session." Leah expressed thankfulness for her (on-staff) interpreter, as well, and then went on to express feeling grateful for the experience of working with interpreters in general, reflecting, "I feel very grateful for this experience. It's really grown me as a clinician."

Forty-five percent (45%) of participants described feeling supported by their interpreters and related feelings of relief. When asked what emotions arise for her related to her interpreter-facilitated work, Rebecca responded, "One of the emotions is enjoyment and relief because I

don't have to do as much work. We are working together." Similarly, Eleanor reported feeling "relief that someone else is bearing witness with [her]."

Forty-five percent (45%) of therapists interviewed reported feelings of camaraderie and/or friendship in their work with interpreters. They spoke about the bond and connection formed with their interpreters through engaging in therapy together, and the pleasure that this connection brings them. Leah, for example, described the fellowship she feels in being able to experience her patients' therapeutic growth together with her interpreter. She stated,

> There's work that we [therapists] do with our patients that's profound... we all have these experiences and it's *so* hard to convey what they are to other people. But I get to share it with [the interpreter]… We both behold it… and we talk about it afterwards... I really have an experience of partnership that's very unique.

Laura also emphasized feelings of camaraderie, developed through the shared experience of doing therapy with her interpreters. She offered,

> A lot of interpreters I've worked with over the years have become friends. You're doing incredible work [together], and the connections become very strong. And, even those who move on to different things, when we see each other, there's a bond, a fondness, an appreciation, and warm feelings.

Other positive feelings, including pride and inspiration, were described by a small number of therapists interviewed. Two participants reported that working with interpreters brings up feelings of pride and "validation" for them. Leah stated,

> I actually feel a lot of pride to be honest. I feel like this is an opportunity for [the interpreter] who knows nothing about this work to be in it and to see how it works. And I feel really proud to bring that every day to somebody who doesn't really know anything about it… I'm representing our fields and it's very important for me to bring integrity to that role – to be my best. I'm more aware of being my best professional self when I'm around her.

Finally, two participants expressed feelings of "wondering" and "inspiration" related to their interpreter-facilitated work. They suggested that these feelings arise in response to the

therapeutic growth that is achieved and to the range of ways that patients can be effectively offered treatment. Leah reported,

> From a bigger perspective, [working with interpreters] is very heartening to me. I have long suspected that our work could… come in less formulaic ways to people – ways that we are less familiar with – that could aid people. And I do see [working with interpreters] so clearly as one of them. I really feel inspired by my growing awareness that, in addition to this, there are probably many other ways… But I also feel inspired that, wow, the human spirit is amazing and people can change, and people shift their lives in unbelievable ways. And it could be with me [in traditional therapy] and it could not.

Negative emotions.

Ninety-one percent (91%) of therapists interviewed reported experiencing negative emotions in reaction to working with interpreters. A number of negative emotions were reported, including, anger/resentment, inefficacy, jealousy, and self-consciousness. The most commonly reported negative emotion was that of anger, with fifty-four percent (54%) of therapists endorsing it. Participants used the words "anger," "frustration," and "resentment" to describe these reactions. When asked what emotions working with interpreters brings up for him, Paul responded, "One of the first ones was frustration; some anger; resentment." Nicole too reported experiencing anger and resentment, particularly when there seems to be a disconnect in the interpreter-facilitated communication. She shared,

> Sometimes [I experience] some resentment when I feel that the interpretation is not going well – that the interpreter is doing something that does not feel right and client's reactions to the translated questions are not necessarily what I would generally expect... [They are not] adequate to the situation. That brings some resentment.

Another common negative experience reported by therapists was that of self-consciousness. Thirty-six percent (36%) of participants described an uncomfortable or "challenging" awareness that interpreters are observing, and perhaps judging, their clinical work. Ama described this reaction, offering,

> In the beginning, it was a little anxiety-provoking, just thinking that you have a third person observing. Their role is not to observe, but you have somebody who is *there*… seeing how you work and what you do, and at times wondering, "Why did you do that?"… It of heightens your [sense of] "Okay, what am I doing and why am I doing it? What are they thinking about what I'm saying? I can't get the words right."

Ines shared very similar sentiments, stating, "Feeling like there is an audience in my clinical work; that can be really challenging. It feels a little bit vulnerable, professionally."

Three therapists reported that working with interpreters induces feelings of inefficacy in them. Rebecca described this experience as "a sense of frustrated efficacy" and a "lack of efficacy." She stated,

> I feel less effective, sometimes, working with interpreters…not being able to use the skills that I have in the way that I can with someone who speaks English…because of the time lag and not knowing how what I am trying to say is being interpreted. You use words in a certain way in therapy – how you phrase things, your tone, and the specific words that you choose are very intentional. And you can't do that with an interpreter.

Eleanor reported having similar feelings of inefficacy before she gained enough experience in interpreter-facilitated therapy to trust that it worked. She shared,

> You're used to being able to go back and forth easily [when talking with a patient] and it is a whole different situation when you use an interpreter… You feel de-skilled – if you haven't had time to develop trust in the therapeutic triad – and that can make you feel insecure.

Finally, three therapists interviewed expressed feelings of jealousy related to their interpreter-facilitated work. They reported feeling envious of the relationships that interpreters have with patients, describing them as "direct relationships" or "closer relationships" and expressed longing to have such relationships with patients themselves. Paul articulated this experience, stating "I feel jealous, because [interpreters] have, in many ways, a closer relationship with the patient than I do."

Processing reactions.

When asked if and how they intentionally process the emotions that arise from working with interpreters, study participants were fairly split in their responses. Fifty-five percent (55%) reported that they do not engage in any deliberate processing of their emotional reactions to their interpreter-facilitated work. Leah stated, "No. I don't really have a good process for [working through my reactions to working with interpreters]… This is the first real conversation I've had about what it's been like." A number of these participants also specifically noted that the systems in which they are employed discourage attending to interpreter-related issues, contributing to their lack of deliberate processing. Patricia, for example, offered,

> I know [my feelings about working with interpreters are] a normal experience, [but] I don't have a lot of colleagues who are working through interpreters, and I don't find the medical doctors and nurses so understanding of what I am doing… So in terms of processing [my clinical work], it wasn't a normal part of it. I think it made agencies little bit uncomfortable – the administrators.

Forty-five percent (45%) of therapists interviewed reported that they do intentionally process their reactions to working with interpreters in therapy. Processing with peers or supervisors (36%); debriefing with interpreters (36%); and practicing mindfulness during and after session (9%) were specified as techniques used.

Nicole shared,

> When I was working with my provisional license I had a supervisor, so I would do all kinds of processing every [supervision] and my reactions to the interpretation process were a part of that. And now, several of my professional colleagues are in similar situations, and we will meet and talk about whatever comes up in our work and process reactions... like case consultation, if you will, with colleagues. And with interpreters, when I'm noticing that I'm having a strong reaction that repeats itself and I see a pattern – whether it's a joyful or a rather resentful pattern – then I meet with the interpreter, one-on-one, and I share a little bit. Not just to process [reactions of] mine, but [also] to discuss whatever needs to be discussed for me to feel that the therapy process is not being compromised.

Similarly, when asked if she has a method for processing the feelings that her interpreter-facilitated work generates in her, Ines reported that she processes with her peers as well as engages in a mindfulness practice. She stated,

> We have a peer support meeting... And I can go and say, "I screwed up" or just, "I'm so aggravated," and they are really great at helping me see how I might have contributed to [the situation]… I also tend to do a lot more mindfulness…in session, I will purposefully take a deep breath or do the exercises that we teach people in our orientation groups. I don't think it's a coincidence that with *all* of my clients who I see with interpreters… we start – and sometimes end as well – with a grounding exercise, a deep breathing exercise, a water exercise, and a gratitude or hope exercise. Those things have helped me say, "I can make it through this session."

The Importance of Setting the Frame of Therapy and Defining the Roles

Though participants varied in how they conceptualized the interpreter's role in treatment, one hundred percent (100%) spoke about the importance of setting the frame of interpreter-facilitated therapy and clearly defining the roles of therapist and interpreter at the beginning of the work. Many study participants also specifically expressed that it is the therapist's responsibility to ensure that this frame-setting occurs.

One hundred percent (100%) of therapists asserted that the therapeutic process benefits from explicitly communicating with the interpreter about roles and "how the therapy works." Marilyn went as far as to identify role clarity as a key characteristic of her most successful interpreter-facilitated psychotherapies. Ama too noted the importance of clearly establishing the interpreter's role and emphasized the therapist's responsibility for this task. She stated,

> You have to make sure they understand what their role is in treatment… it's not just the interpreter's responsibility but also the responsibility that we have as clinicians in terms of orienting them… reviewing what the expectations are and the ethical guidelines.

Emily also highlighted the importance of role clarity, and indicated that it is the therapist's task to establish clear expectations with interpreters about the therapy process. She offered,

> Setting clear boundaries and clear expectations is helpful… [This means] having a conversation with [the interpreter] beforehand to share my hopes and expectations and [talking] about how we're going to work together… We need to be clear on what our jobs are.

Forty five percent (45%) of study participants spoke about the importance of explicitly setting the frame and defining roles with patients in interpreter-facilitated therapy, in addition to doing so with interpreters. Eleanor, for example, asserted that she "always" engages in "setting the stage upfront" and explaining to patients both "the role of the interpreter" and how the therapy will work. Ines reflected on how interpreters' role confusion can contribute misunderstandings on the part of patients. She stressed the importance of clearly defining roles, stating,

> I think patients sometimes are confused as to the difference between an interpreter and a provider. They think that the interpreter can help them get Medicaid or help them with their sadness. And I think interpreters sometimes forget that [that is not their role] too, and then their role confusion comes in to play for patients too… So I find myself defaulting a lot to the education piece about people's roles and responsibilities.

Likewise, Laura described explicitly communicating with both interpreters and patients about the overarching model that guides treatment, how this informs the roles involved, and the practicalities of how communication will occur. She offered,

> We provide orientation for our interpreters. We explain to them the dynamics… and what we're trying to do… orient them to our model. When we meet with the clients we also talk about… how we will work together… I remember very early on [in my interpreter-facilitated work], [a patient] sat down and I addressed them in English, looking at them. Their response was, "Don't they know I don't understand them?"… And so it became really clear how important it is to explain to people how this works.

Word-for-Word Versus Summary-Based Interpreting

Sixty-four percent (64%) of therapists interviewed expressed feeling that, at times, summary-based interpretation is preferable to word-for-word interpreting. Five of these (45%) reported that the level of exactness that they prefer depends on the phase of therapy and their

goals for the session. Ama, for example, stated, "Depending on what I'm doing with the client in the session, my expectations in terms of what [the interpreter is] going to do – whether it's going to be exactly saying everything that's going on, or summaries – is going to vary."

Study participants explained that when a patient is sharing particularly emotionally upsetting material, such as a trauma memory, word-for-word interpreting is less important and can even be "inappropriate," as it can interrupt and "bring down" the therapeutic process. However, participants indicated that when doing an initial assessment or a suicide assessment (at any point in therapy), they need as much word-for-word exactness as possible. Emily clearly articulated these preferences, stating,

> At different times during therapy I need different kinds of interpretation. For example, when I'm doing an intake or an assessment I need to know exactly what the client says. So I need [the interpreter] to interpret bit by bit by bit... and when somebody starts talking about suicide, I need to know all of it. You can't gloss over it. I need the interpretation sentence by sentence almost, or thought by thought… But then there will be times when the client just needs to get the story out and if the interpreter interrupted every few sentences, it would break it up in a way that wouldn't be conducive to getting it out… like in the middle of the trauma story, I don't want to interrupt for interpretation… I can wait a while to hear the whole story.

Two study participants (18%) expressed a more global openness to a summary-based interpreting style. They described reservations about the effect that word-for-word interpreting can have on the therapeutic process. Rebecca stated, "The way that we use interpreters, we don't expect them, require them, to interpret everything word-for-word. In my mind, that brought the process down." Similarly, Laura expressed her general comfort with summary-based interpreting, and then went on to echo the more context-based preferences discussed above, noting that she finds summary-based interpreting particularly appropriate when working with issues of trauma. She offered,

> It's very common for interpreters not to interpret 100% and then later to remember something and to be like "oh, I forgot to tell you something." And for me, that's *fine*, as long as they're remembering. Then, I also have the strong belief that with this level of

trauma, if some detail isn't shared, it's ok. I don't feel like I *have* to know *everything*. I think the important things get shared.

The Importance of Therapist Flexibility

Fifty-five percent (55%) of therapists interviewed expressed that therapist flexibility is essential when working with interpreters. Some participants spoke about the importance of flexibility in terms of therapist willingness to make adjustments to the norms of traditional therapy. Rebecca passionately emphasized this point, asserting,

> You, [the therapist], are the one that has to change, not the client and not the interpreter – you are the one that has to adjust what you are doing. You have to let go of your preconceived ideas about how you are doing therapy, and what therapy is going to be, and how you are going to deliver it, and what type of interventions you can use… [it's] a complete mind shift from doing regular therapy… I just can't believe that using an interpreter to just interpret word-for-word, and thinking you are going to have the [only] relationship [with the patient], and [expecting] that it's going to be the same as regular therapy – that that could be an effective model.

Patricia also emphasized the importance of therapist flexibility in terms of willingness to shift from the expectations of traditional therapy. She described the unique benefits and challenges of working with interpreters who come from the same small ethnic communities as patients, and who, at times may have trauma histories similar to those of patients, and/or preexisting relationships with patients outside of the therapy. She reflected, "[At first] it was like, 'Oh my god, what's going on here?' but the reality was that this was [calling for] more of a systems approach… You just have to shift. *Flexibility* – it's really, *really* important."

Participants also spoke about the importance of therapist flexibility in terms of adjusting to the uniqueness of each interpreting scenario. Nicole, for example, noted the importance of the therapist recognizing that each interpreter is unique and may have different strengths or styles. She stated,

> It's very important for the therapist to have very fluid expectations and be ready to change – to recognize that interpreters are different, that they're not a standard interpretation

machine or device… For me as a clinician, it's really super important to be aware of the need to be flexible and to be able to adjust in my style of doing therapy. For example, if I am noticing that the statements that I say and the questions that I ask are too long, and this specific interpreter is not able to keep up, then it would be a good idea for me to consider shortening up my sentences.

The Importance of Pre-Sessions and Post-Sessions

Ninety-one percent (91%) of therapists interviewed spoke about the importance of setting aside time to meet with interpreters, both before and after sessions. These meetings were commonly referred to as "pre-sessions" and "post-sessions." Study participants described using these meetings in a number of ways. Most participants emphasized the value of using pre-sessions to communicate with interpreters about expectations for therapy. They spoke about using pre-sessions to establish roles, set the frame of therapy, review confidentiality, explain the therapist's goals for the session, and describe what the experience of the session might be like. When speaking about pre-sessions and post-sessions, Leah stated,

> Any conversation that could be had beforehand or afterword about the nature of what happens, or what could potentially happen – what they are getting into – would be important… and conveying ahead of time what the intention of that piece of the work is… so that they know what you need from them to make it go well.

Study participants also described pre-sessions as opportunities for interpreters to orient them to any relevant cultural issues that might affect a session and/or to collaborate on how to communicate with patients about therapeutic concerns that could be difficult to translate across cultures and languages. Eleanor, for example, stated, "So if the language itself doesn't contain our [therapy] words, then what do you do? You really need to debrief with your interpreter ahead of time to make sure that such expressions actually exist." In terms of post-sessions, participants spoke about the value of using them to "debrief" with interpreters. Many participants described debriefing in terms of reviewing any cultural aspects of the session that the therapist may not have fully grasped. Debriefing might also involve reviewing the interpreter's reflections in

general. Patricia offered, "I really have to allow time for the interpreter to debrief and to get their reflections… I always spend time after the session reflecting with them, asking, 'Are there cultural issues that I didn't understand?'" Ama echoed these statements, reporting,

> The way I try to set it up is that we meet and spend a little time before the session and we spend a little time at the end of the session. [I ask] were there things that stood out for them, or were there parts that were difficult, or things that they wanted to say that they didn't get around to telling me? Sometimes I name my [impressions], saying, "I was having this reaction. Did you have a different reaction or did you get that from the client? Was I misunderstanding the body language?" Especially if they're cultural brokers and they understand [cultural norms of body language].

Study participants also emphasized the importance of post-sessions as opportunities for therapists to offer interpreters feedback and to discuss potential adjustments for future interpretations. Marilyn stated, "It's very important to have a little session afterwards with the interpreter to talk over the things that worked or didn't work, and to make sure to give them great feedback about what they did."

Finally, most participants also described using post-sessions to emotionally process session content. For some participants, this consisted of processing sessions in a communal way that included receiving emotional support from interpreters. For others, it consisted mainly of offering support to interpreters and attempting to mitigate interpreter vicarious trauma. Ines, for example, spoke about the need to attend in pre-and post-sessions to the "emotional well-being of interpreters." This was done through psychoeducating about vicarious trauma, checking in about interpreters' emotional reactions, and offering additional support options. She described,

> I have had to take on the emotional well-being of the interpreters a little bit more…I found myself saying, "You may find yourself having nightmares. You may find yourself thinking about this story when you don't want to think about it." And so, yeah,… the pre-interview and the post interview are really important… to check in with [interpreters], say we have a support group… educate them a little bit about vicarious trauma.

Systemic Barriers and Limitations

      Lack of clinician training.

      Ninety-one percent (91%) of therapists interviewed reported that they received no training on how to work with interpreters before beginning to do such work and that they essentially had to learn on the job. One participant, Ines, stated that the hospital where she works provided a 90-minute training.

      In addition to gaining hands-on experience through their jobs, three participants (27%) reported that after beginning their interpreter-facilitated work, they sought training independently, in the form of conferences, workshops, or online seminars.

      Seventy-three percent (73%) of therapists interviewed stressed the need for therapist training on how to work with interpreters. These sentiments were expressed in different ways. Numerous participants asserted that their training was inadequate preparation to engage in interpreter-facilitated work. For example, when asked whether she had undergone any training in how to work with interpreters, Eleanor stated, "No, I wish they had had such a thing. We really needed it." Likewise, when asked whether she felt her training experiences had prepared her to conduct interpreter-facilitated therapy, Emily, responded, "No, not really – not sufficiently, certainly."

      In addition, some participants stressed the need for therapist training by stating directly that it should be required for therapists who will be working with interpreters. Paul stated, "I think [training] should be mandated – that people who are going to provide services to people whose dominant language is not English should learn how to work with an interpreter." Ines echoed these sentiments, asserting, "I think it's incredibly important that people are really trained in it, particularly if you want to work with the [LEP] population."

Limited interpreters available for less common languages.

Fifty-five percent (55%) of therapists interviewed reported that the lack of interpreters available for less common languages and/or dialects often leaves them with less-than-optimal interpreter arrangements. Therapists reported that the limited availability of interpreters in certain languages contributes to working with less trained interpreters, working with phone-interpreters even when in-person interpreters are preferred, and continuing to work with interpreters even when it becomes clear that they are not a good fit. Emily highlighted the increased likelihood of using untrained or poorly trained interpreters when working with less-common languages, observing that interpreter agencies tend to have lower training standards for these languages. She stated, "For some of the more difficult [to find] languages like Oromo or TjiKalanga, people don't actually have to be trained [to work] for the language line… and it's frustrating because they simply don't know what they are doing."

Ines, too, spoke about challenges created by the limited resources available for working with certain languages, particularly in terms of ensuring that patients work with interpreters who are a "good fit." She described how she and a patient discontinued working with a phone interpreter that both felt was a poor fit, but then struggled to arrange a replacement. She went on to reflect,

> Being able to say, "Oh you're not a good fit for me, give me somebody else," – most people don't have these kinds of resources… folks aren't available. It depends on the language… [This case] was unfortunate because this was a tribal language, that there aren't a lot of resources for.

Furthermore, multiple therapists reported that a lack of interpreters for particular languages and/or dialects impairs their ability to maintain interpreter consistency. In fact, the lack of in-person interpreters available for the language needed was the most frequently-cited

reason for failing to maintain interpreter consistency despite preferring to do so. Marilyn

highlighted this point when asked whether she uses the same interpreter throughout a treatment,

stating,

> Yes, when possible, but that's not always possible. We're not talking about a Hispanic clinic where you just have Spanish speakers. We're talking about a clinic where we see people from 58 different countries, so the range of language and dialect is huge.

Limited funding and time.

Sixty-four percent (64%) of therapists interviewed reported that limited funding and/or

time undermines their ability to conduct interpreter-facilitated therapy in the ways they feel are

most effective. Paul, for example, reported that despite his preference for working with in-

person interpreters rather than phone interpreters, using in-person interpreters (aside from the

hospital's one on-staff Spanish interpreter) was rarely approved by the hospital due to the cost.

He stated, "It cost a lot of money and it was rarely done." He went to emphasize the importance

of increasing funding for interpreter services, offering,

> Systemically and financially, there was definitely a cost associated with [using interpreters] and so it was actively discouraged… the way to change [that systemic norm] is through looking at the funding sources… and increasing the budget [for language services].

Patricia too described struggling with cost-based limitations on her work with interpreters. She

reported that, in multiple work settings, despite her preference for working with trained

interpreters whose role is clearly defined and restricted to interpretation, financial limitations

contributed to an expectation that she instead use untrained bilingual staff, who also had other

professional relationships with patients. She stated,

> They'd say, "Oh, just use the case manager," and I found that to be inadequate and not a good thing, but I felt like I could not bring that up because they didn't have the money to hire interpreters. [It was] the same in a hospital – a psychiatric hospital. My discomfort was not really a topic administrators wanted to hear about because of the costs.

Patricia went on to note that financial limitations undermined her interpreter-facilitated work even in a setting where there *was* funding to hire employees specifically as interpreters. She reported that in this setting the interpreters she hired often left to take better-paying positions, reflecting, "I think in a matter of six months I went through a couple interpreters and this made it very difficult. Once I trained them, they found other positions that they could get more money for."

Furthermore, multiple therapists reported that, due to limited funding, their places of employment engage volunteer interpreters. While acknowledging the access to patients that this strategy enables, participants also spoke about the challenges associated with depending on unpaid workers. Ama noted that volunteer interpreters may be less able than paid interpreters to prioritize their interpreting commitments, making them less reliable. She stated,

> [We need] more funding so we are paying people to do this. It takes a lot of hard work. People think, "Oh, it's such a cool program, such a great idea. I know a foreign language, I'll interpret," and then they come [volunteer], and… their lives are busy. It's not really a priority… There have been situations where we have gone through three interpreters. And it was disruptive, but, because we are working with volunteers who also have their own lives, this is just the nature of the beast.

Two therapists interviewed specifically noted that limited time resources (which are easily traced to limited funding resources) affect the quality of their interpreter-facilitated work. Rebecca stated,

> I think that if we had the luxury to of being able to spend more time with interpreters before and after each session that would improve our work tremendously… But unfortunately, because we are in a productivity-driven environment, we don't have the opportunity to do that a lot of the time.

Institutional culture and devaluation of interpreters.

Forty-five percent (45%) of therapists interviewed reported experiencing systemic devaluation of interpreters that undermined their successful integration of interpreters into

therapy. Participants indicated experiencing this both as a minimization of the importance of the role of the interpreter and a minimization of the skill that interpreting involves. They reported encountering this systemic devaluation both in the institutions where they work and in the field of psychology in general. Paul, for example, described a pervasive lack of institutional support for his interpreter-facilitated work, stating,

> It was generally discouraged… They didn't want to hear about it. It wasn't necessary to them, [they felt] like, "Things are going just fine when we don't [hire interpreters to help us] treat these patients. Why are you making this an issue?"... and, "It takes work." And so, it was actively discouraged by supervisors, by other interns, by other people on the unit, and certainly by the [nurse who doubled as the] staff interpreter.

Paul went on to describe how, beyond failing to recognize the importance of the interpreter's role, coworkers and administrators at this hospital also underestimated the skills needed to perform the role well. This often leads to the engagement of inappropriate bystanders as ad-hoc interpreters. He offered,

> On the unit, they would just grab anyone who speaks Spanish and use that person for interpretation… They have no understanding – that it is actually a *thing* to be an interpreter. It takes training and skills. It is not, "oh, just use anyone." Or they will use a family member or a child! And these are trained professionals that are doing this.

Similarly, Patricia reported that administrators in multiple employment settings did not want to hear about the topic of hiring an interpreter and became "uncomfortable" if she brought it up. Likewise, she too spoke about the tendency of agencies to underestimate the training and skill required to interpret effectively, leading them to engage bilingual coworkers as interpreters. She stated,

> I think [working with interpreters] was really downplayed in most agencies I worked with, whether it was in an inpatient facility or community mental health. They would say "use a nurse that speaks the language" or "just use the case manager, they know the community"… and I have found that to be totally inadequate… being bilingual does not make you an interpreter. They are totally different skill sets. I don't know why that's not acknowledged. [Being bilingual] doesn't prepare you to convey my words adequately. It doesn't prepare you to facilitate the therapeutic process.

Other participants spoke more generally about the resistance in the field of psychology to engaging interpreters and recognizing the importance of their role. Ines reported, "I just got back yesterday from a [global mental health] conference. I was surprised and horrified that everyone was like, 'Oh my god, [work with] interpreters? No way!'" Laura too commented on this resistance in the field to accepting the interpreter as a valuable part of the therapy process. She described clinicians' negative reactions to trainings she has given on working collaboratively with interpreters, stating,

> Most of the time…people are like, "You're not doing therapy! That's not therapy with someone else in the room!"… There's a lot of resistance… a lot of pushing back about what we're presenting… [a lot of] devaluing of interpreters instead of using [the presence of the interpreter] as an asset.

Suggestions for Training

As part of their semi-structured interviews, study participants were asked what should be included in training for therapists on working with interpreters. This section is less theme-based than those preceding it, as the investigator wants to include all valuable suggestions, no matter how prevalent across interviews.

Participants asserted that the following topics should be covered in training for therapists on working with interpreters in psychotherapy:

1) The role and skill set of the interpreter. Numerous participants also emphasized training that underscores the importance of valuing and respecting the interpreter's role.

2) The importance of the interpreter-therapist working relationship, and treating the interpreter like a partner in the therapy.

3) Effective communication with the interpreter and the importance of feedback. Study participants spoke about the need to teach therapists how to orient interpreters to their expectations and how to engage in conversations about the interpreter's expectations, ethics code, etc. Nearly all participants also emphasized the importance of training therapists to engage in pre-sessions to

establish expectations for an upcoming session, and post-sessions to offer interpreters feedback, invite interpreter reflections, and/or process emotional reactions.

4) The potential for interpreter vicarious trauma and the importance of supporting the interpreter. Study participants emphasized that trainings should include teaching therapists to psychoeducate interpreters about vicarious trauma, monitor interpreter reactions to traumatic content, explicitly check-in with interpreters about their reactions to sessions, and offer interpreter support groups (whenever possible).

5) Language and word choice issues. Participants suggested that training should communicate the reality that not everything will translate directly from one language to another and that "word-for-word" translation is not always preferable or even possible. Thus therapists should be trained to develop more than one way to explain or describe symptoms, therapeutic concepts, etc. In addition, trainings should direct therapists to speak succinctly and avoid using jargon, idioms, and colloquialisms; likewise, that humor should be used with caution, as it is often culturally-bound.

6) Changes in the timing and flow of therapy; namely, how to time interventions when using an interpreter and the need to schedule more time because everything is said twice.

7) The different types of interpreting and when to use each. This includes phone interpreting versus in-person interpreting, simultaneous interpreting versus sequential interpreting, and word-for-word interpreting versus summary interpreting.

8) Establishing confidentiality and safety with an interpreter in session.

9) How to arrange the seating with interpreters in session.

10) Dynamic issues including transference, countertransference, and power. Regarding issues of transference, multiple participants specifically noted the importance of training clinicians on potential reactions of patients to the race, ethnicity, or gender of an interpreter. Numerous participants stressed that training ought to emphasize a communal rather than hierarchal power structure in therapy.

11) The importance of clinician flexibility.

12) Systemic issues and how to work with them.

In addition, multiple therapists recommended that training include an experiential component, such as a role-play. Ines spoke powerfully about this, stating,

A role-play is required. You cannot just talk about these things with folks, you have to get that experiential piece in…. have interpreters [reenact scenarios] that have happened, and coach people on how to work through them… What does a mental status exam really look like [using an interpreter]? We talk about confidentiality [in

training], but what does that really sounds like [in session]? And then giving
[trainees experience with] those hic-ups that therapists run into – [clients saying]
"Well in my country there is no confidentiality, there's no concept of that," or the
interpreter and the client talking to each other on the side – giving [trainees] a
chance to experience setting those boundaries [in the training]. Because I think that
is the most difficult part.

Other participants suggested including a video illustrating a variety of interpreting

scenarios, including both potential challenges and successful interpretations. One therapist

suggested that trainings might include a discussion panel with therapists who are

experienced in working with interpreters, so students might benefit from a range of first-

hand experience and advice.

Chapter V

Discussion

This chapter discusses the themes that arose during the interviews with therapists experienced at working with interpreters. These themes included the importance of relationships in interpreter-facilitated psychotherapy, therapists' conceptualizations of the role of the interpreter in the therapy process, the value of interpreter consistency, and the myth of interpreter neutrality. This discussion chapter also explores therapists' emotional reactions to working with interpreters, the importance of therapist flexibility, the value of setting the frame of therapy and defining roles, the need for allotting time for meeting with interpreters before and after therapy sessions, and when different types of interpreting are preferable. Systemic barriers and limitations to working effectively with interpreters in psychotherapy are also examined. Lastly, implications of this study's findings for training, practice, and future research are discussed. Due to the limited sample size of this exploratory study, as well as the dominance of study participants who work specifically with torture survivors and asylum-seekers, the reader is cautioned against generalizing these results to a larger population of therapists working with interpreters. At best, these results put forth hypotheses for further examination and future research.

Relationships and Interpreter Consistency

The majority of the therapists interviewed stated that building positive relationships with interpreters benefits the therapy process. This was asserted in terms of both interpreter-therapist relationships and by a smaller, though still majority percentage, interpreter-patient relationships. Establishing a good interpreter-therapist relationship – for some, even forming a primary alliance

with their interpreter – was described as essential to successful interpreter-facilitated psychotherapy. Likewise, study participants asserted that interpreter-therapist trust is vital due to how much therapists depend on their interpreters. They also indicated that a trusting relationship improved communication and feedback between therapists and interpreters and enabled them to work collaboratively through challenges and conflicts.

There has been no empirical research focusing on the quality of the interpreter-therapist relationship, and there is relatively little reflection on this issue in the literature in general. However, the findings of this study that relate to the importance of the interpreter-therapist relationship are consistent with the few articles that do address this topic. Two of these are based on the authors' reflections on their own experiences in the field (Hamerdinger & Karlin, 2003; Tribe & Thompson, 2009b). They not only emphasize the importance of the interpreter-therapist relationship, but also suggest making the interpreter-therapist relationship the primary alliance in the therapeutic triad (Hamerdinger & Karlin, 2003; Tribe & Thompson, 2009b). Tribe and Thompson (2009b), for example, encourage "building a fixed alliance in advance" between therapist and interpreter, in which "the clinician and the interpreter are slightly closer to one another than they are to the client, and can share their observations of the work and support one another" (p. 19). Likewise, research shows that many therapists struggle to establish positive working relationships with interpreters and that this, in turn, undermines their ability to establish alliances with their patients (Raval and Smith, 2003). The focus placed on the interpreter-therapist relationship in the current study, together with the above-quoted research, suggests that building a positive working relationship with interpreters should be highly prioritized by therapists, and perhaps even initiated prior to beginning therapy with a patient. To explore this

finding further, additional research is warranted on the impact of the interpreter-therapist relationship on therapy outcomes.

In addition, study participants' emphasis on trust in the interpreter-therapist relationship warrants reflection. Systematic qualitative research has identified lack of interpreter-therapist trust as an obstacle to developing positive interpreter-therapist relationships (Brisset et al., 2013; Raval & Smith, 2003). Though generally considered a crucial aspect of any positive relationship, in this study trust in the interpreter-therapist relationship was directly linked to how much therapists must *depend* on their interpreters. Thus, this study likely reflects feelings of vulnerability on the part of therapists as well. Though many therapists in this study viewed themselves as ultimately "in charge" of sessions, the deep need they expressed for interpreter-therapist trust may be indicative of the degree to which interpreters do, in fact, wield power in session. These findings are consistent with Brisset et al.'s (2013) observations that clinicians' fears about loss of control and power and their efforts to maintain control and power, undermine the establishment of trust between therapist and interpreter. They further concluded that power and control should be balanced between all three therapy participants, and that when imbalances occur, the therapeutic relationships are undermined. Both conclusions, together with the findings of this study, suggest that therapists who can acknowledge and tolerate their vulnerability with interpreters may be more successful in building trusting, positive working relationships with them.

The majority of study participants asserted the therapeutic benefit of a positive interpreter-patient relationship and stressed the importance of trust in this relationship as well. There is no existing systematic research on the impact of the quality of interpreter-patient relationship on therapy outcomes. While literature clearly states that it is important for patients

to establish trust with their interpreters, especially regarding confidentiality (Brisset et al., 2013; Miller et al., 2005), it is mixed regarding the broader idea of interpreter-patient relationships. Therapists' positive emphasis in this study on the benefits of strong interpreter-patient relationships appears unique amongst studies that use systematic analysis. Systematic qualitative research has shown that patients value trust and emotional closeness with interpreters (Brisset et al., 2013) and that they do form powerful, supportive relationships with them (Miller et al., 2005). Furthermore, Tribe and Thompson (2009), in reflecting on their own experiences working with interpreters, note that they can serve as safe, positive attachment figures for patients. However, existing systemic research studies reflect that most clinicians tend to struggle with negative feelings regarding interpreter-patient relationships in therapy (Brisset et al., 2013; Miller et. al, 2005; Raval & Smith, 2003). Therapists frequently feel that patients form primary therapeutic alliances with their interpreters; they often feel excluded from or peripheral to the therapy process. Likewise, many therapists expressed feeling that patients' strong relationships with interpreters undermine their ability to conduct therapy and hinder therapeutic process (Miller et al., 2005; Raval & Smith, 2003). Considering that the patient-therapist relationship is regarded as central to effective psychotherapy across approaches, it is understandable that therapists would feel at a loss, should the primary relationship in treatment not include them. Feelings of jealousy and exclusion were expressed in this study as well, but by only three study participants (27%).

The finding that seventy-three percent (73%) of study participants described positive interpreter-patient relationships as being beneficial to therapy (rather than disruptive to it) may reflect a shift within the field of psychotherapy. This shift might reflect a greater acceptance of the reality that patients do form relationships with their interpreters, whether therapists

encourage this or not (Brisset et al., 2013). Additionally, this finding may reveal a willingness to think of interpreter-patient relationships as a resource (Tribe & Thompson, 2009), rather than a threat. In fact, multiple study participants made statements expressing acceptance that it may take them longer than the interpreter to form an alliance with the patient. Alternately, it is also possible that this finding reflects a bias in this sample, as those who responded to the call for study participants may have been those therapists most driven to advocate for a change in the status quo as to how clinicians work with interpreters.

Considering the weight placed on positive interpreter-patient relationships, the fact that the majority of study participants reported a strong preference for maintaining interpreter consistency is hardly surprising. Study participants stated that interpreter consistency is integral to the development and maintenance of positive relationships, trust, and safety within the therapy, between all therapy participants. Likewise, interpreter inconsistency was labeled disruptive to the therapy process; it was described as "traumatizing and harmful." Therapists described how "bringing a stranger into" the intimacy of therapy is jarring for patients. Additionally, therapists reported a preference for interpreter consistency because it provides opportunities to learn how to work with, or even to "train" their interpreters. This finding is consistent with current suggested best practice guidelines in the literature, which state that whenever possible, the same interpreter should be used throughout a treatment (Hamerdinger & Karlin, 2003; Raval & Smith, 2003; Tribe & Morrissey, 2004). Despite this guideline, however, this study reflects a discrepancy between therapists' desire to maintain consistency and their ability to do so. Though ninety-one percent (91%) of therapists reported that they prefer to maintain interpreter consistency, only fifty-five percent (55%) stated that they are reliably able to do so. Most named financial and systemic limitations as responsible for their failure to maintain

consistency. While systemic limitations undeniably impact therapists' ability to maintain interpreter consistency, it is possible that this discrepancy also reflects therapists' ambivalence about patients developing close relationships with interpreters and (possibly unconscious) efforts to maintain the primacy of their own relationships with patients. Empirical research into the impact of interpreter consistency versus inconsistency on treatment outcomes, patient experiences, and therapist experiences would further elucidate this issue.

The Role of the Interpreter

All study participants interviewed described the interpreter's role as one involving both facilitating communication and culture brokering. This finding is generally consistent with the literature, which reflects that the most common conceptualization of the role of the interpreter in therapy is that of cultural broker (Searight & Armock, 2013; Tribe & Lane, 2009). It is commonly considered beneficial to have interpreters help clinicians place client symptoms and behavior into cultural context. However, there are also some articles based on the clinical experiences of the authors that advise caution about how the role of cultural broker is executed (O'Hara & Akinsulure-Smith, 2011; Smith et al., 2007; Tribe & Thompson, 2009). These assert that it is a mistake to assume that because a patient and interpreter share a language (or even a country of origin), they also share a culture. They emphasize that it is important to explore the patient's personal world view in session, rather than to have the interpreter explain what they assume this world view is. Likewise, two participants in this study noted the value of collaborative cultural exploration and reflection through directly questioning patients about their experiences and beliefs, rather than relying solely on the interpreter for cultural information. Though a point expressed by a minority in both the literature and in this study, this caution

against the assumption of sameness may be all the more salient as therapists increasingly ask interpreters to perform as cultural brokers.

As to having interpreters orient clients to "the culture of therapy," this is rarely specifically addressed in the literature. Two articles note the value of having the interpreter act as a "therapy conduit" (Miller et al., 2005, p. 31) or a "socializing agent" (Searight & Armock, 2013, p. 32) to normalize the therapy experience for clients who come from cultures without psychological treatment as a positive norm. However, it is unclear what is involved in the normalization mentioned by these authors. It seems likely that this process of normalization is relatively passive and consists mostly of an interpreter's accepting presence in session. Current literature indicates that most therapists would see interpreters *actively* educating clients on the process and/or benefits of therapy as falling outside of their role, both because it would involve interpreters offering their own opinions and experiences and because many interpreters lack mental health education or training. Furthermore, it is likely that most therapists would see this as an infringing on their role as therapist. With regards to this study, it is probably not a coincidence that three of the four therapists who conceptualize the interpreter's role as including orienting patients to US and therapy cultures, also described the interpreter's role as actively relational. These study participants appear to conceptualize the role of the interpreter as fairly active and interpersonal in general.

Forty-five percent (45%) of study participants said that the interpreter is an extension of their voice, describing the interpreter's role as a more restricted one. This appears to lean towards a black-box model in which interpreters are viewed as tools or instruments, rather than as people with agency of their own (Miller et. al, 2005; Searight & Armock, 2013; Tribe & Lane, 2009). Lipton et al. (2002) reflect that some interpreters feel disrespected by this

conceptualization, stating that being regarded "merely as an 'adjunct' or 'instrument'" contributes to a interpreters sense of being "treated like a second-class employee" (p. 27). Interestingly, some of the therapists in this study who made black box, "non-person" statements about interpreters, also made statements asserting the interpreter's relational role in therapy. This conflictual finding is particularly interesting in light of Searight & Armock's assertion that the black box model of interpreting is generally considered "less than optimal" by both therapists and interpreters (2013, p. 25). It would suggest that, even if therapists acknowledge the relational dynamics inherent to interpreter-facilitated psychotherapy, and even if they recognize the potential benefits of a relational approach, at times, they still gravitate towards minimizing the personhood of the interpreter. This is likely tied, at least in part, to therapists' anxiety about the presence of another person in their therapy and about another relationship forming with their patient, over which they have little control. This finding is consistent with the systematic qualitative research conducted by both Brisset et al. (2013) and Raval and Smith (2003). Their research showed that clinicians tend to experience contradictory wishes regarding the role of the interpreter and to place inconsistent role demands on them. A study examining the conditions under which clinicians tend treat the interpreter as an extension of themselves (versus when they tend to engage them as separate individuals) could elucidate these complex dynamics.

Forty-five percent (45%) of study participants viewed the interpreter's role as actively relational, such that they support patients, help them process emotions, and bear witness to their stories. This is consistent with the findings of Miller et al. (2005) in their qualitative exploratory study. It is also consistent with the more anecdotally-based literature (Searight & Searight, 2009; Tribe & Thompson, 2009; Tribe & Thompson, 2009b). A number of study participants also specifically emphasized that the interpreter is free to connect with and respond to patients

beyond the mere the repetition of the therapist's words. Though expressed by a minority of study participants, this theme still represents a notable shift from the interpreter's role as discussed in the existing literature, and appears unique to this study. Research has documented that patients often experience interpreters as a supportive presence, whether the therapist conceptualizes their role as such or not (Miller et al., 2005). Likewise, the literature states that some conceptualizations of the interpreter's role include the interpreter advocating on behalf of the client (Searight & Armock, 2013; Tribe & Morrissey, 2004). Still, most of the literature reflects the point of view that an interpreter should rarely, if ever, respond directly to patients in a way that represents their own thoughts and feelings. Hamerdinger & Karlin (2003) state, "an interpreter is not supposed to interject comments or opinions in their interpretations" (p. 4). Like the weight that study participants placed on interpreter-patient relationships, the active, relational conceptualization of the interpreter's role within this study may represent a shift in the field of psychotherapy, reflecting an increased recognition of interpreter personhood and a growing conceptualization of interpreters as relational resources. It is also possible that this theme is overrepresented in this study's population. The majority of study participants work with torture survivors; and, as such, are highly attuned to issues of power and control. A number of these study participants noted efforts to undo a patient's helplessness and disempowerment in the therapy session. They stated that part of this effort involves recognizing the humanity and right to a voice of *everyone* in the session. The disempowered experience of interpreters who are required to only express the thoughts of others, leaving no room for sharing their own experience, has been noted by researchers (Raval & Smith, 2003).

An even greater shift away from the literature is represented by those few study participants who advocated for the benefits of having interpreters speak about their own histories

and traumas with patients. In a review of the literature, Miller et al. (2005) were the only

researchers to highlight the potential benefit of having an interpreter speak about his or her own

experience. However, they mentioned the benefits of in the context of interpreters becoming

emotionally overwhelmed due to the personal relevance of patient clinical material. They

explained that, rather than being inherently disruptive, an interpreter's open expression of

emotion offers an opportunity. Processing an interpreter's reaction and the patient's experience

of that reaction, together as a group, can ultimately be therapeutic for the patient. Neither study

participant who highlighted the benefit of discussing an interpreter's history did so with the goal

of helping patients process an overt emotional reaction on the part of the interpreter. Rather,

they asserted that for interpreters to share aspects of their history (whether or not they are

struggling to contain an emotional reaction) can serve the purpose of normalizing patient

experience and decreasing patient isolation. This is more closely consistent with Miller et al.'s

later (2005) statement that,

> A common concern of refugee clients is that their experience will not be adequately
> understood by someone who has not lived through it. Having an interpreter present who
> has shared some version of the client's experience seems to serve as a kind of
> reassurance, conveying to clients that they have an ally in the room who does know what
> they have been through. (p. 35)

In general, conceptualizing the interpreter's role as one in which they are free to share

relevant information from their own history, may be akin to a group therapy model, in which

participants benefit from learning that they are not alone in their suffering and have the

opportunity to support one another. However, this suggests a particularly ambiguous role for the

interpreter, as it appears to place them in both the role of group member and group facilitator.

Another potential framework through which to consider this level of interpreter disclosure is that

of a mentor or role model relationship. It is possible that in allowing interpreters to share their

own experiences, there is an opportunity for them to become (healthfully) idealized objects for

patients. As people who have had similar struggles to those of patients and who are now

established and employed in new lives, interpreters may serve as sources of hope for patients.

This potential role for interpreters has been noted by Tribe and Thompson (2009), who state "the

interpreter can be seen as a model for the client, showing that it is possible to survive leaving

home, changing country, migration, finding work, and even thriving in a new country" (p. 7).

Thirty-six percent (36%) of study participants viewed part of the interpreter's role as

emotionally processing clinical material with therapists and offering them emotional support.

There is very little literature considering this potential aspect of the interpreter role. Miller et al.

(2005) do note that some of the therapists in their study expressed gratitude for the supportive

presence of interpreters and for the role interpreters would take in processing material after the

session. However, existing research and guidelines primarily focus on the therapist's

responsibility for monitoring interpreters' emotional state and ensuring that they have the support

they need to process difficult material (Paone & Malott, 2008; Searight & Searight, 2009; Tribe

& Lane, 2009; Tribe & Morrissey, 2004), rather than engaging interpreters in emotionally

supporting therapists. Consistent with this focus in the literature, most therapists in this study

spoke about offering support to interpreters, particularly in terms of defending against vicarious

trauma. Only a small percentage of study participants indicated receiving emotional support from

interpreters. It is possible that this reflects a view among therapists that emotional

processing/intelligence is part of the role of the therapist, but not of the interpreter. Additionally,

if therapists consider themselves responsible for the care of their interpreters' emotional health, it

is possible that this position of responsibility feels at odds with one of receiving care as well.

Considering the relative absence in the literature of this perspective, the fact that thirty-six

percent (36%) of study participants asserted that the interpreter's role could include helping

therapists process emotional reactions to clinical material may reflect an increased recognition of the interpreter as a relational resource in therapy.

Forty-five percent (45%) of therapists interviewed conceptualized interpreters as collaborators and partners who work with them rather than for them. Some of these study participants spoke about intentional efforts to create an egalitarian working relationship. The need for therapists to let go of some ego and control when working collaboratively with interpreters was asserted repeatedly. Again, the representation of this stance in this study may be somewhat skewed due to the number of study participants working with torture survivors. They may have a heightened awareness of power dynamics. Regardless, this perspective represents an essential respect for the professional role of interpreters. The focus of these study participants on creating an egalitarian working relationship appears in line with existing research, which has shown that power differentials in interpreter-therapist relationships can undermine the alliance and be at odds with building trust (Brisset et al., 2013; Raval & Smith, 2003). This is consistent with the conclusions of Brisset et al. (2013) as well as Raval and Smith (2003) that power must be balanced between all therapy participants. However, the current literature suggests that rather than recognizing the need to share power, many therapists try to compensate for their loss of power through becoming more rigid and controlling in session (Brisset et al., 2013; Lee, 1997). Comparatively, the findings of this study suggest increased acceptance by therapists that working with interpreters inevitably involves sharing (some) power with them, and active efforts to adjust accordingly.

Interpreter Neutrality is a Myth

One hundred percent (100%) of therapists interviewed asserted that interpreters are not neutral, whether or not they might strive to be. They stated that as human beings, interpreters have personalities, emotions, and opinions that inherently affect their presence in the room and how they interpret the statements of therapists and patients. While the current literature recognizes this lack of neutrality (Bot 2005; Hamerdinger & Karlin, 2003; Lee, 1997; Miller et al 2005; O'Hara and Akinsulure-Smith, 2011; Searight & Searight, 2009;Tribe & Morrissey, 2004; Westemeyer, 1990), practice guidelines that require interpreters to be as "invisible" as possible – like those recommending interpreters use the first person and sit relatively out of sight – seem designed to support the illusion of neutrality and the appearance of direct communication between therapist and patient (Bot, 2005; Miller et al., 2005; Tribe & Thompson, 2009b). Likewise, some literature overtly perpetuates the illusion of interpreter neutrality. Paone & Malott (2008) advocate "stressing to the client that the interpreter is a neutral party" when explaining their role (p. 138). In their general principles for working with interpreters, Searight & Searight (2009) describe ways to "facilitate 1:1 interaction" between therapist and patient, as though the interpreter is a neutral conduit through which they are speaking (p. 446). It is interesting that while some study participants regarded an interpreter's unique personhood as a resource (which added support and richness to the therapeutic process); others spoke about the interpreter's lack of neutrality as an unavoidable, though unfortunate, reality. In light of the ambivalence expressed in the literature, these findings suggest that, while the personhood of the interpreter may be increasingly recognized by therapists, the desire for neutrality (even if only an illusion), continues to influence how therapists work with interpreters.

Therapists' Emotional Reactions to Working with Interpreters

This study's findings on therapists' emotional reactions to working with interpreters are consistent with the limited research on this subject. Study participants reported both positive and negative emotions in reaction to their interpreter-facilitated work. Not surprisingly, therapists tended to feel positive emotions when interpretations went "smoothly" and negative emotions when interpretation was challenging or difficult. The majority of study participants reported feeling "joy" and "gratitude" in their work with interpreters. This is consistent with the findings of Miller et al. (2005), which reflected therapist gratitude and sense of being supported by interpreters. The negative emotions described are also consistent with literature. Feelings of anger when interpreters break the boundaries of their role, feelings of jealousy and exclusion related to the interpreter-patient relationship, feelings of self-consciousness about interpreters potentially evaluating their work, and feelings of inefficacy, have all been noted in qualitative studies similar in design to this one (Kaufert & Koolage, 1984; Miller et al., 2005; Raval & Smith, 2003). Likewise, research suggests that these negative feelings diminish as therapists become more experienced in working with interpreters, and as specific interpreter-therapist pairs gain experience working together (Miller et al., 2005). This experience was reported by many of this study's participants as well. Some study participants who spoke about negative emotions specifically noted that they experienced those emotions "at the beginning" of their interpreter-facilitated work, or when starting work with a new interpreter. In addition to lending additional support for the value of maintaining interpreter consistency, these findings highlight the need for therapist training and on-going support in their interpreter-facilitated work.

The fact that so many study participants reported having no means of intentionally processing their emotional reactions to working with interpreters seems inherently problematic.

The need for therapists to be aware of their emotional reactions to clinical material is widely accepted in the psychodynamic psychological community. Experienced therapists are expected to process this material and be vigilant in their consideration of how their emotional reactions and personal emotional needs may impact their therapeutic work. The failure of fifty-five percent (55%) of study participants to recognize the importance of doing this with regard to their interpreter-related reactions may, again, reflect underlying desires to deny the impact of the interpreter on the therapy process and to act "as though" the relationship were actually a dyad. It may additionally reflect therapist resistance to acknowledging the aspects of their negative emotional reactions which may be countertransferential. For example, therapists may be resistant to acknowledging that their jealousy regarding interpreter-patient relationships might reflect their own need to feel like "the one" who helps the patient. They may find it easier to take their negative feelings at face value and blame interpreters, rather than to explore the parts of these experiences which may result from their own projections.

Furthermore, research shows that therapists tend to project their own negative experiences with interpreters onto patients, leading them to incorrectly assume that patients prefer to discontinue their work with interpreters rather than continue (Kline et al., 1980). This suggests that unprocessed negative emotions on the part of the therapist have the potential to be particularly destructive to the therapy process and the patient experience. The current study shows the prevalence of therapists' negative feelings about working with interpreters and the absence of methods for the intentional processing of these emotions. This finding, together with existing research, highlight the importance of agencies creating systemic means of training, support, and processing for therapists working with interpreters.

The Importance of Setting the Frame and Defining Roles

All of the therapists interviewed emphasized the importance of setting the frame of therapy and explicitly defining the roles of therapist and interpreter. This corroborates existing literature and best practice recommendations (Lee, 1997; O'Hara and Akinsulure-Smith, 2011; Paone & Malott, 2008; Tribe & Lane, 2009; Tribe and Morrissey, 2004; Tribe & Thompson, 2009). Tribe and Morrissey (2004), for example, state that establishing a working contract at the onset of therapy that covers confidentiality, roles, responsibilities, and boundaries helps therapy proceed as smoothly as possible. Likewise, role ambiguity has been found to contribute to feelings of disempowerment on the part of both therapists and interpreters, to contribute to difficulties forming a positive interpreter-therapist alliance (Raval & Smith, 2003), and to negatively impact the quality of interpretation (Lee, 1997).

Though its importance is widely agreed-upon in the field, research suggests that the task of establishing therapeutic frame, defining roles, and adhering to these during treatment is challenging for many therapists. Brisset et al. (2013) assert that ambivalence around the interpreter's role leads clinicians to require interpreters to fill different roles at different times, asking for varying levels of neutrality, support, and input that can leave interpreters feeling conflicted. Raval and Smith (2003) report that therapists seem to experience contradictory wishes regarding the role of the interpreter. They describe participants asserting, at different times in the same interview, that: (1) they wish for interpreters to be forthcoming in offering their opinions about what is happening in session; and (2) they experience the interpreter sharing their opinions as intrusive. Likewise, O'Hara and Akinsulure-Smith (2011) report that interpreters frequently complain that clinicians ask them to break the boundaries of their roles,

regardless of the frame established at the beginning of their work together. Study participants also expressed varied and sometimes seemingly contradictory expectations of interpreters.

These findings highlight the importance of training for therapists who work with interpreters. Training can help therapists to understand the various roles that interpreters might play, to prepare for how they, as therapists, might experience these roles in session, and to practice effectively incorporating these roles into treatment.

Word-for-Word Versus Summary Interpreting

The majority of therapists interviewed stated that, at times, they prefer summary-based interpretation over a relatively verbatim repetition of patient speech. There is mixed commentary in the literature on this issue. Consistent with the sentiments expressed in the current study, Lee (1997) does list summary-based interpreting as a "format" of interpreting that is "helpful when clients need to tell their stories on emotionally charged topics" (p. 484). She also points out that using this format requires a high level of trust between therapist and interpreter. That said, interpreter summaries of patient speech are most often discussed in the literature as examples of how interpreters might distort communication. Summaries are often mentioned in descriptions of the challenges that therapists face in their interpreter-facilitated work (Lee, 1997; Raval & Smith, 2003). In these cases, summaries are clearly viewed negatively. This view of interpreter summaries and related feelings of frustration were reported by some participants in this study as well. However, a majority of study participants spontaneously asserted the advantage of accepting summary-based interpretations within certain emotionally-charged therapy scenarios. This development appears to reflect a shift from the

common expectations of interpreters. It suggests increased flexibility among therapists and an increased willingness on their part to trust and rely on interpreters.

Importance of Therapist Flexibility

Six study participants emphasized that therapist flexibility is important in interpreter-facilitated psychotherapy. This is not surprising, considering that working through an interpreter means engaging with someone from another culture that may have conceptualizations of suffering and healing which are very different from those espoused by western psychology. Cross-cultural treatment in general demands a certain level of therapist flexibility. As noted previously, there is little focus in existing literature on what therapist factors improve or impede interpreter-facilitated therapy. While this study's finding regarding the importance of therapist flexibility in interpreter-facilitated psychotherapy appears to be relatively unique, some authors have commented that working in interpreter-facilitated therapy requires "adjustments" on the part of therapists. Hamerdinger and Karlin state, "The work of therapy in a counseling session using an interpreter will never be the same work that is done when both the therapist and the client speak the same language…[the] therapist has to…be willing to make adjustments for those differences" (p. 1-2). The emphasis on therapist flexibility in this study may represent a growing awareness among therapists about the benefits of adjusting to the interpreters' presence in session, rather than attempting to maintain the normal dyadic therapy frame, or the illusion of this frame.

Importance of the Pre-Session and Post-Session Meetings

All but one participant spoke about the importance of setting aside time to have pre-session and post-session meetings with interpreters. Pre-sessions were used to communicate about expectations, including setting the frame of therapy, defining roles, describing therapeutic goals for an upcoming session, and psychoeducating interpreters about vicarious trauma. Post-sessions were described as opportunities to offer interpreters feedback about their interpretation, to hear interpreter reflections on the session (cultural or otherwise), to process clinical material together, and to check on the interpreter's emotional well-being and offer support when needed. Both the emphasis on pre-session and post-session meetings, and the uses described, are consistent with existing research and best practice guidelines (O'Hara and Akinsulure-Smith, 2011; Paone & Malott, 2008; Searight & Searight, 2009; Tribe & Lane, 2009). This finding highlights the value of on-going communication and feedback in the interpreter-therapist relationship.

Systemic Limitations

Study participants spoke about a number of systemic limitations and barriers that limit their ability to engage in interpreter-facilitated treatment. These included lack of training provided by graduate programs and/or employers, lack of interpreters available for less-common languages, limited funding, and competing time/productivity demands. This corroborates existing research. These limitations, as well as the need for increased systemic support for interpreter-facilitated work, are repeatedly noted in the literature (Brisset et al., 2013; Miller et al., 2005; Paone & Malott, 2008). Likewise, participants in this study and in existing literature both emphasize the need for clinician training (Hamerdinger & Karlin, 2003; Miller et al., 2005;

O'Hara and Akinsulure-Smith, 2011; Tribe & Lane, 2009). Research has shown that problems in interpreter-facilitated work result from lack of training on the part of medical providers and interpreters (Gerrish et al., 2004; Tribe & Lane, 2009; Tribe & Morrissey, 2004).

In addition, forty-five percent (45%) of study participants reported experiencing systemic devaluation of interpreters in the agencies where they worked and in the field of psychology in general. Likewise, study participants spoke about the failure of colleagues and administrators to recognize and appreciate the complex skill set required to effectively interpret. This too is consistent with available research, which indicates that interpreters tend to be under-paid and are generally regarded as low-status employees (Granger & Baker, 2003; Lipton et al., 2002; Raval & Smith, 2003; Tribe & Thompson, 2009) whose skill set is misunderstood and underestimated (Brisset et al., 2013; Hamerdinger & Karlin, 2003; Paone & Malott, 2008).

It is important to note that this prevalent devaluation of the role of the interpreter is most likely reflective of society's disregard for and devaluation of patients with limited English proficiency (LEP). LEP patients are highly likely to also be persons of color, undocumented immigrants, and/or of low socio-economic status. The failure of the mental health system to value interpreters, despite the research demonstrating how their presence improves both access to care and the quality of care provided, must be considered an expression of systemic racism. Drennan and Schwartz (2002) have commented on this as well, arguing that the on-going failure of institutions to recognize the communication needs of patients should be seen in the context of historical racism. They state that clinical work in the context of impaired provider-patient communication perpetuates dehumanizing stereotypes and racist discourses in psychiatry through the silencing and obscuring of the population needing interpreters. Likewise, Tribe & Lane (2009) state, "failure to tackle communication problems through the routine provision of

interpretation and advocacy services could lay the health service open to the charge of institutional racism" (p. 237).

Ultimately, it seems clear that improving therapists' ability to effectively work with interpreters must involve a shift in the systems that support them. Both this study and the literature strongly indicate that increased systemic funding and support are needed to effectively and ethically engage interpreters in therapy. Moreover, until the role of the mental health interpreter and the skill it involves are more widely understood and valued, therapists and their LEP patients are bound to struggle with inadequate systemic resources. Considering that legislation requiring equal care for LEP patients already exists (Snowden et al., 2007; US DDHS, 2001), stricter regulations about implementation and oversight appear necessary to force institutions to comply with existing legislation and prioritize interpreter services properly.

Limitations of the Study

There are several important limitations to this study. First, the design of this study prevents the results from being generalized to a larger population. Due to its exploratory nature, there was no control group for a basis of comparison, and the sample size was quite small. Furthermore, the qualitative data gathered consists of the perceptions of the study participants and are limited to their lives. They cannot be generalized to others in their community and are not intended to be representative of therapists providing interpreter-facilitated therapy as a whole. Similarly, because the research was designed to be qualitative, it did not confirm or deny other research about the experience of therapists working with interpreters. In addition, the sample was recruited using a network approach, which may have led to selection bias. In particular, a large percentage of the study participants worked with asylum-seeking and refugee

populations, and so were particularly attuned to dynamics of trauma and power. This may have affected their responses and the frequency of certain themes. In addition, since the data are based on self-report, they may be affected by bias or social desirability factors. Finally, the primary investigator conducted all the interviews, and thus the study had the potential for researcher bias. Specifically, there was a presupposition that working with interpreters requires specialized knowledge and techniques, as well as a presupposition that therapists' negative feelings and resistances contribute to challenges in interpreter-facilitated therapy.

Although there were these limitations, the use of this qualitative method allowed for a rich detailed report of how the study participants conceptualize, experience, and conduct interpreter-facilitated psychotherapy. Also, it allowed for information to be spontaneously discovered, which provided illustrative anecdotes and reflections beyond was what specifically asked. The wealth of data collected lends itself to be further examined in future research studies.

Implications for Future Research

There are several important considerations for future research. First, given the limitations of this study, it would be imperative to research this area with a larger sample size with the power to generalize more readily. Additionally, this exploratory study focused on therapists' perspectives. Considering the implications regarding collaboration, it would be critical to research these topics from the point of view of interpreters experienced in mental health interpreting. This could generate further information on how interpreters experience the different approaches to integrating them into psychotherapy as well as information on what they feel is needed to perform their role(s) well. Likewise, researching these topics from the point of view

of LEP patients would be helpful to learn how patients experience different interpreting models. Research examining the impact of the quality of interpreter-therapist relationships on treatment outcomes is warranted to test the hypothesis generated by this study regarding interpreter-therapist relationships being a critical variable in the success of interpreter-facilitated therapy. Research into the effect of interpreter consistency versus inconsistency on treatment outcomes, patient experiences, and therapist experiences is also indicated. A study examining the impact of therapist training in interpreter-facilitated work and of on-going therapist supervision/processing of interpreter-facilitated work could produce valuable guidance. Likewise, research examining the result of interpreters and clinicians receiving joint supervision and holding regular pre-sessions and post-sessions would also add valuable information that could be used to develop best practice guidelines.

Finally, considering the implications in this study regarding the benefits of relationships, consistency, and a collaborative approach in general, it could be particularly fruitful to examine whether training interpreter-clinician pairs as unified on-going treatment teams would improve treatment outcome.

Implications for Practice and Training

Although there was variability in what study participants reported, key themes did emerge that raise important considerations for training and practice. When working with an interpreter in psychotherapy, it is important to cultivate a positive working relationship between therapist and interpreter. Developing a strong alliance and foundation of trust should be prioritized, and can be viewed as part of a healing therapeutic frame into which therapists bring patients. Approaching interpreters with respect and recognition for the complexity of their role

will aid in this process. Furthermore, as developing an alliance takes time and experience, working consistently with the same interpreter over time supports the development of a strong interpreter-therapist relationship.

It is important to understand that, regardless of the model of interpreting used in session, interpreters are not neutral interpretation machines. Each carries unique feelings, opinions, memories, biases, and motivations which inevitably impact their presence in session and influence the interpretation they provide. The interpreter's unique personhood influences the therapeutic process and experience, just as that of the therapist does. It can be destructive to treatment to try to behave as though the interpreter is not "really there."

Likewise, patients are bound to experience an interpreter as another person in the therapy. They will develop relationships with interpreters, and these relationships may be intense. They are likely to have emotional reactions to interpreters and may develop transferences to them. Though this introduces a challenging and complex dynamic, it can be a source of rich clinical material as well as of support, comfort, and hope for patients. A positive interpreter-patient relationship benefits the therapy process.

With rare exceptions, it is preferable to use the same interpreter for the duration of a therapy treatment. Maintaining interpreter consistency is essential for creating safety and trust in the therapy. It allows essential relationships to develop between all therapy participants. Failing to maintain interpreter consistency can be disruptive to the therapy process and the patient's engagement. Furthermore, being familiar with how each other works contributes to a smoother therapy process.

Therapists should familiarize themselves with the various conceptualizations of the role of interpreter and consider which they feel best fit their approach to therapy. Viewing

interpreters as cultural brokers is extremely common and interpreters can often serve as an important source of cultural information that can provide insight into a client's presentation. That said, speaking the same language does not necessarily indicate that an interpreter and a patient share the same culture. It is important to avoid the overdependence on interpreters to provide cultural information when it would be more fruitful to explore cultural layers of work directly with clients.

It is valuable to consider conceptualizing the role of the interpreter as one involving active relational engagement with patients. Interpreters can serve as sources of emotional support, participate in patients' emotional processing, and bear witness to patient pain and growth. Some therapists have found that having interpreters share about their own painful histories has helped patients feel less isolated. Some have found that interpreters can serve as role models or sources of hope for patients. In considering these types of more relationally-active interpreter involvement, establishing boundaries is especially important.

It is essential to communicate with interpreters about roles, ethics, and expectations for working together prior to the start of therapy. This conversation should take into account the interpreter's conceptualization of their role as well as the therapist's, and any conflicting perspectives should be discussed in advance so shared expectations are agreed upon before the start of work. It is also critical to explain the role of the interpreter to patients, and to explain how interpreter-facilitated therapy will work.

Therapists and interpreters should have regular pre-sessions and post-sessions to collaborate on their work together. These can be used for both parties to provide feedback and reflections, to adjust interpreting technique, to consider cultural layers of the work, and to emotionally process difficult clinical material. It is important to check with interpreters about

the emotional impact of traumatic sessions and symptoms of vicarious trauma, and to ensure that they have the support they need.

At times, summary-based interpreting may be preferable to word-for-word interpreting. This is particularly appropriate when frequent stopping for interpretation would be experienced as disruptive, such as when a client is sharing a trauma history.

Therapist flexibility is essential to successful interpreter-facilitated therapy. The shift from the dyadic to triadic frame and the cross-cultural aspect of the work both require adjustments on the part of the therapist. Likewise, every interpreter-therapist-patient triad generates unique dynamics and different challenges, requiring flexibility of approach from triad to triad.

Therapists need training in working with interpreters. Agencies serving LEP patients should offer such trainings (either through engaging external training resources or developing their own) to the therapists they employ. Likewise, therapists working with interpreters should seek out such training, if none is provided by employers or graduate schools. Ideally, training should involve an experiential component, allowing therapists to practice engaging with interpreters and navigating a variety of challenges that can arise. Furthermore, whether in a structured training or not, it would be beneficial for therapists to spend time reflecting on how they might experience the various aspects of interpreter-facilitated therapy that others have found challenging: the shift from dyadic to triadic treatment frame; the patient developing a strong, perhaps primary relationship with the interpreter; the interpreter's feelings, opinions, or personality being expressed (whether verbally or non-verbally) in session, etc. Furthermore, it may be fruitful for agencies to consider developing and offering joint trainings for therapists and interpreters. In light of the implications in the current study regarding the benefits of

relationships, consistency, and collaboration, dyadic training for interpreter pairs conceptualized as unified on-going treatment teams is worth consideration.

Therapists should be mindful of reactions to working with interpreters and engage in on-going intentional processing of these reactions, particularly when the therapist is new to interpreter-facilitated work or when beginning work with a new interpreter. In the same way that therapists might seek out peer consultation, supervision, or additional training when engaging with clients who elicit strong feelings in them, therapist reactions to working with interpreters warrant curiosity and self-reflection.

At present, there are significant systemic barriers to effectively integrating interpreters into psychotherapy. Therapists should advocate for language services in their places of employment. Working to raise awareness within organizations regarding cultural competence and needs of patients with limited English proficiency is indicated. It may be easiest to incorporate these efforts into existing agency trainings or initiatives regarding diversity. Drawing attention to APA Guidelines relevant to integrating interpreters into assessment and treatment may also help raise awareness. Principle D of the APA Ethics Code (APA 2002) states that all persons are entitled to "equal quality in the processes, procedures, and services being conducted by psychologists." Principle E states that must try not to allow bias related to culture, race, ethnicity, or language to affect their work. Furthermore, the APA's 2002 Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists state that multiculturally sensitive work will "respect the language preference of the client." Finally considering the federal legislation mandating language services for LEP patients, it may be beneficial for psychologists to advocate within their state psychological

associations as well as with state legislators for more rigorous stare implementation and oversight of federal mandates.

Conclusion

This study aimed to discern important considerations for effectively integrating foreign language interpreters into psychotherapy. In particular, this study sought to elucidate how therapist-factors influence the process of interpreter-facilitated psychotherapy and what therapists can do to improve their interpreter-facilitated work. There is a dearth of information on this topic, particularly in terms of systematic research. In this exploratory study, a qualitative research design combining ethnographic and grounded theory was used. Eleven therapists experienced at conducting interpreter-facilitated psychotherapy were interviewed and the resulting qualitative data were analyzed using McCracken's long interview methodology.

There were several important themes discovered in the semi-structured interviews. The importance of developing on-going positive relationships between all therapy participants was strongly indicated. In particular, the study revealed the value of a strong interpreter-therapist alliance. Therapist awareness of power dynamics and efforts to create a collaborative partnership with therapists were described as beneficial. Likewise, the importance of allotting time to meet with interpreters before and after sessions to plan and process together was highlighted.

This study indicated that setting the frame of therapy and defining roles, with both interpreters and patients, prior to the start of therapy, is key to moving forward successfully. A number of conceptualizations of the role of interpreter were described. The impossibility of true neutrality or "invisibility" on the part of the interpreter was also highlighted, as was the related need to be aware of the impact of the interpreter's personhood on the process. There was an

emphasis on engagement of the interpreter as a relational resource for both patient and therapist, above and beyond that reflected in the current, limited, literature on the subject. However, therapist ambivalence regarding the role of the interpreter and the desire to minimize interpreters' personhood and presence were also found. The use of different types of interpreting at different times in therapy was suggested. Similarly, therapist flexibility was viewed as a requirement for successful interpreter-facilitated work.

Therapists described a range of emotions elicited by their interpreter-facilitated work and, most often, did not have any method for intentionally processing these. Those therapists who did have systems of processing stressed their importance. Systemic barriers including lack of therapist training, limited funding and time, and inadequate interpreter availability were found to play key roles in undermining therapists' ability to work with interpreters. In addition, systematic devaluation of interpreters and the skill required for their role was highlighted as a barrier to working with interpreters effectively.

The findings of this study suggest several important implications for therapist training and practice, namely: the importance therapists of being flexible; the value building collaborative relationships with interpreters; the need to regularly communicate expectations and feedback with interpreters; and benefits of engaging the personhood of interpreters in the therapy process.

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Appendix A

Informed Consent Agreement

Clinician Factors in Interpreter-Facilitated Psychotherapy:
An Exploratory Study

You are invited to participate in a research study. Before you agree to participate in this study, you should know enough about it to make an informed decision. If you have any questions, ask the investigator. You should be satisfied with the answers before you agree to be in the study.

Purpose of the Study:

This study explores interpreter-facilitated psychotherapy from the perspective of psychologists experienced in working with interpreters. This study aims to understand your thoughts and opinions about the ways working with an interpreter changes the therapy process, the role of the interpreter in therapy, what training for clinicians on working with interpreters in therapy should include, and what clinicians can do to improve their successful collaboration with interpreters. There is currently very little research on foreign language-interpreting in psychotherapy, despite its importance in treatment of clients with limited English proficiency, a rapidly increasing population in the United States. This study will be used to examine the demands working with an interpreter places on clinicians, to develop more comprehensive theories of the process of interpreter-facilitated therapy, and to develop training recommendations for such work. A doctoral student at the Graduate School of Applied and Professional Psychology (GSAPP) at Rutgers University is conducting this study as a fulfillment of dissertation and doctoral requirements. It is anticipated that 15 individuals will participate in this study.

Study Procedures:

You will be interviewed about your experiences, thoughts, and opinions in regards to how you conduct interpreter-facilitated psychotherapy. You will asked about your experiences and opinions in regards to the frame and process of interpreter-facilitated therapy, the relationships, roles, and dynamics involved in interpreter-facilitated therapy, and about any barriers you perceive to successful collaboration with interpreters. **The interview will take about one and one half hours.** Interviews will be audio taped to contribute to the authenticity of the study.

Risks: The interview focuses on your experience and thoughts as a therapist. It is my hope that the interview will be a positive experience for you. However, recalling some professional experiences may be unpleasant for you and you may experience some discomfort when answering questions. If you experience emotional distress related to the study, please contact the researcher and discuss this with her, so that she can assist you and help provide you with referrals as necessary.

Benefits: Participation in this study may not benefit you directly. However, the knowledge that we obtain from your participation, and the participation of other volunteers, may help us create more comprehensive theories of interpreter-facilitated therapy, improve training for therapists, and improve service delivery to clients with limited English proficiency. Sharing your experience as a clinician working with interpreters may also provide a valuable opportunity to reflect on various aspects of this experience.
Confidentiality: This research is **confidential**. This means that that the research records will include some information about you, including your age, gender, job title, and years of experience providing interpreter-facilitated psychotherapy . Your name will only appear on consent forms and will be kept

separate from research records. I will keep this information confidential by limiting access to the research data and keeping it in a secure locked location. The research team and the Institutional Review Board at Rutgers University are the only parties that will be allowed to see the data, except as may be required by law. Your responses will be grouped with other participants' responses and analyzed collectively. All common identifying information will be disguised to protect your confidentiality. This will include changing your name and other demographic information (i.e. job title, experience level).

Interviews will be transcribed by the principal investigator and audio recordings will be destroyed three years after the study. All audio recordings, transcripts of interviews, or other data collected from you will be maintained in a locked file cabinet and destroyed three years after the study. Audio recordings will be assigned a case number.

Compensation: There is no compensation for participation in this study.

Contact: I understand that I may contact the investigator or the investigator's dissertation chairperson at any time at the addresses, telephone numbers or emails listed below if I have any questions, concerns or comments regarding my participation in this study.

Sara Detrick, PsyM (Principal Investigator)	Karen Riggs Skean, PsyD (Chairperson)
Rutgers University, GSAPP	Rutgers University, GSAPP
152 Frelinghuysen Rd	152 Frelinghuysen Rd
Piscataway, NJ 08854-8085	Piscataway, NJ 08854-8085
Telephone: 609.217.4497	Telephone: 732.445.2000
Email: saradetrick@gmail.com	Email: kskean@aol.com

If you have any questions about your rights as a research subject, you may contact the IRB Administrator at Rutgers University at:
Rutgers University, the State University of New Jersey
Institutional Review Board for the Protection of Human Subjects
Office of Research and Sponsored Programs
3 Rutgers Plaza
New Brunswick, NJ 08901-8559
Tel: 732-932-0150 ext. 2104
Email: humansubjects@orsp.rutgers.edu

Rights as a Participant: Participation in this study is VOLUNTARY; you may decide to participate at any time without penalty to you. If you decide to participate, you may withdraw from the study at any time without penalty and without loss of benefits to which you are otherwise entitled. If you withdraw from the study before data collection is completed your data will be removed from the data set and destroyed. Also, if you refer other individuals for participation in this study, your name may be used as the referral source only with your permission

I have read and understood the contents of this consent form and have received a copy of it for my files. By signing below, I consent to participate in this research project.

Participant Signature _____   Date _____

Investigator Signature _____   Date _____

CONSENT FOR AUDIO TAPING

You have already agreed to participate in a research study titled, Clinician Factors in Interpreter-Facilitated Therapy: An Exploratory Study conducted by Sara Detrick. We are asking for your permission to allow us to audiotape (make a sound recording) as part of that research study.

The recording(s) will be used for analysis by Ms. Detrick.

The recording(s) will be distinguished from one another by an identifying case number not your name.

The recording (s) will be stored either as a password protected digital file or on audio-cassette tapes stored in a locked filing cabinet, and transcribed by the principal investigator.

All audio recordings will be maintained in a password protected digital file or a locked filing cabinet and deleted three years after the study is completed. All transcripts of interviews will be maintained in a password protected electronic document or a in a locked file cabinet. All transcripts will be destroyed three years after the study.

Your signature on this form grants the investigator named above permission to record you as described above during participation in the above-referenced study. The investigator will not use the recording(s) for any other reason than that/those stated in the consent form without your written permission.

Subject (Print) _____

Subject Signature _____ Date _____

Principal Investigator Signature _____ Date _____

Appendix B

Demographic Questions

Date:

Age:

Gender:

Race:

Job Title:

Employment Setting:

Type of Doctoral Degree: Ph.D.   Psy.D.   Ed.D.

Years of experience as a therapist:

Years of experience working with an interpreter:

Number of cases treated with the help of an interpreter:

Appendix C

Semi-Structured Interview

1) Did you receive any training in working with an interpreter? If yes, please describe this training.

2) Do you feel your training and educational experiences prepared you adequately for interpreter-facilitated work?

3) Please describe your current comfort level integrating an interpreter into your therapy work.

4) What is the model or frame within-which you conduct interpreter-facilitated therapy?

5) How do you conceptualize the interpreter's role? In relation to you and in relation to the patient?

6) Do you work with the same interpreter throughout treatment? Why or why not?

7) How do you think this affects the treatment?

8) How do you arrange the seating in interpreter-facilitated therapy and why?

9) What issues, if any, have come up for patients related to the presence of the interpreter?

10) How did you address these?

11) Do you find it helpful/important in discussions of racial, religious, cultural, or ethnic issues to address the patient's reactions/transference to the interpreter's race, religion, etc?

12) Does working with an interpreter change how you see or experience your role as a therapist, and if so, how?

13) Has working with an interpreter changed the way you think about mental health and/or therapy, and if so, how?

14) Has the way in which you work with interpreters changed as you have gained more experience, and if so, how?

15) What are some of the ways working with an interpreter challenges you?

16) What, if any, emotions does working with an interpreter bring up for you?
17) In what ways do you process your reactions to working with an interpreter?

18) What has stood out about the roles/dynamics in which you felt the work was most effective/successful?

19) Least effective/successful?

20) Is there anything you think you could do as a clinician to improve your interpreter-facilitated work?

21) What prevents you from doing these things?

22) In reflecting on your work with interpreters, what do you think training for clinicians on working with interpreters in psychotherapy should cover?