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Opportunity for Development or Necessary Nuisance? The Case for Viewing Working with Interpreters as a Bonus in Therapeutic Work

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... To know another language is the best and most exciting way of discovering the strengths - and limitations - of the one with which one has grown up... I have come to value my own translators as my wisest readers - they ask searching questions about precise meanings, they hear the rhythms of long stretches of interwoven writing, they send lists of alternative translations of particular words, all of which add a little meaning in the other language here, and take it away there, all of which are possible, none of which are perfect equivalents. (AS Byatt, The Times 11.2.06)

Abstract

This paper explores the central role a language interpreter can play in the process of the therapeutic relationship. Although others have described the changes to the therapeutic dyad that the presence of a third party (an interpreter) brings, little attention has been paid to the advantages and additional opportunities of this altered therapeutic situation. This paper details these gains and further argues that clinicians who are willing to gain experience of working with interpreters will find that benefits accrue at the micro and macro levels: at the micro level, through enhancement of their work with individual non English speaking clients, and at the macro level through learning about different cultural perspectives, idioms of distress and the role of language in the therapeutic endeavour. This is in addition to developing skills to fulfil legal and professional requirements relating to equity of service provision. Some ideas are offered to explain the negative slant that runs throughout the literature in this area and tends to colour the overall discussion of therapeutic work with interpreters and, before the final section, makes some specific suggestions which may help maximise the gains possible in such work while reducing difficulties.

Key words

interpreters; therapeutic work; clinicians; skills; legal; professional

Introduction

Any change to traditional therapeutic practice may be viewed as having both positive and negative impacts which need to be considered. In some cases, the same change appears to some practitioners to lead to positive changes, while others see it in negative terms. Nowhere is this more striking than in the literature on therapeutic work with interpreters. Contrast, for example, the view of Haenal (1997) that the delay involved in interpreting leads to a lack of spontaneity and obliges the therapist to be always one step behind in understanding his or her client's emotional reactions, with the view of Westermeyer (1990) and Raval (1996) that this same

delay can be helpful in offering the therapist time to think during exchanges between client and interpreter.

This paper will seek to explore the positive aspects of working therapeutically with interpreters, in an effort to counterbalance a literature that can appear somewhat negative about the challenges and possibilities involved. In part this is because engaging in three-way relationships can be unfamiliar for clinicians, and also because some clients who come as refugees and need the help of an interpreter in therapy can present with difficult and traumatic material. These issues are explored at some length in a companion paper (Tribe & Thompson, 2009).

Why working with an interpreter adds additional value

This paper will argue that the involvement of an interpreter often enhances therapeutic work. As stated in Miller *et al* (2005 p31):

as the first point of contact for prospective clients, interpreters must normalize psychotherapy to clients from cultures in which psychological and psychiatric services are unfamiliar, frightening or highly stigmatized.

While it is important not to oblige interpreters to take on the role of junior clinicians by explaining services and collecting client information without the involvement of the practitioner (Westermeyer, 1990), it is also true that the simple presence of the interpreter plays a role in normalising the experience of therapy and can be helpful in combating fear or stigma. As noted in a number of studies, when there is language concordance (when health worker and patient speak the same language or have access to qualified interpreters) better access to health care, quality of communication, patient satisfaction, fewer emergency visits and improved compliance with health regimes have been found (Lee *et al*, 2002; Eyton *et al*, 2002; Riddick, 1998; Stolk *et al*, 1998; Perez-Stable *et al*, 1997; Manson, 1988; Morales *et al*, 1999). Further, recent research in East London has underlined the desire of clients to be provided with trustworthy and empathic interpreters, again echoing the way in which an interpreter can function as a safe attachment figure (Alexander *et al*, 2004).

Interpreter as cultural broker

Many writers have also made mention of the importance of the interpreter as a 'cultural broker' (Holder, 2002), recognising that what is being interpreted is more than simply language and includes aspects of culture and individual worldview. This is not simply a question of the interpreter providing information about culture or background (although this can be very useful), but relates more to the suggestion that therapeutic work with interpreters allows for a **transitional space** (Pezous, 1992) in which culture can be negotiated. Dearnley (2000 p20) states:

I have found discussions between therapist and interpreter particularly useful when we have had different views,

making reference to occasions when interpreters have offered her observations that she found enlightening, about both the material and the therapeutic relationship. We, too, have experienced on a number of occasions the value of both cultural information provided by an interpreter and their observations about client material and process, whether related to culture or not. In one example, Thompson recalls working with a client who had experienced overwhelming socio-political trauma, with the result that all the professionals involved in her case explained all aspects of her difficulties in relation to her experiences. It was the interpreter's empathic remark that:

'I feel so sorry for her - she seems to have been treated as a servant in her own family'

that allowed Thompson to re-evaluate her somewhat narrow focus on trauma work with this client to include much more about her domestic and family experience, something that had seemed to be somewhat lost in the work before this.

Similarly, Tribe (1997) describes an occasion in which an Ethiopian client shared a dream with her which appeared to have a fairly straightforward meaning related to life-changing events which he had been hoping would come about for several years, believing they would bring back meaning to his life. The interpreter suddenly interrupted in quite an agitated manner to inform her that in the culture (of the interpreter and client) there was a tradition of women interpreting dreams. When there appeared to be a latent or hidden content to dreams, it was believed that if the woman chose to speak about it, it would come true, while if she did not speak of it, it would not happen. The interpreter was seeking to warn her to be sensitive to this and not to interpret the dream. Tribe states that without the interpreter's warning she might have made a culturally inappropriate and potentially damaging intervention. This example illustrates the need for clinicians to ensure that there is an atmosphere of sufficient trust and respect for

interpreters to feel confident to raise issues and share their knowledge.

There can, of course, be dangers in assuming any commonality of culture between an interpreter and client, even if they hail from the same country, ethnic group, social class, age and gender. As Drennan & Swartz (1999 p182) point out:

assumptions of a monolithic culture that can be summarized and commodified for easy psychiatric consumption

are inherently problematic and ignore the diversity within any culture or subculture. Patel (2003) also stresses the difficulties that may arise when interpreters 'feel obliged to offer cultural interpretations' which may not be accurate. Thus ideas taken from such interchanges with interpreters should be shared with clients in a spirit of open enquiry rather than reified into a fixed and rigid idea of another's 'culture'.

Symbolic value of the interpreter

While it is true that no one person has the same experience as another, it is important to consider how the symbolic value of having an interpreter present may contribute to the work. It is certainly a message from the therapist to the client about how far the former is prepared to go to meet them, which can be powerful at a political level in societies in which foreigners are the recipients of discriminatory treatment. Interestingly, Raval (1996) reported that therapists found it easier to talk about racism and discuss cultural differences with their clients when an interpreter was present, again suggesting that the role of the interpreter has aspects not explained by simply looking at the communication or dynamics between the parties involved.

In this regard, Raval (1996) notes the need for additional help in 'joining between' therapist and client when working cross-culturally, a role that can be provided by the interpreter. An example might illustrate this, and also demonstrate Raval's further point that it is important not to have so high a degree of fit between therapist and client (and interpreter) that new information cannot be generated. In work with rape survivors, the different perceptions of many traditional cultures and societies,

in which the woman survivor is often blamed and stigmatised for her experiences, can be explored with the aid of the different perception prevalent in the UK. Thus the clinician might ask the client whether they are aware of this difference in perceptions and what they make of it. The lack of fit allows for exploration, and often for a helpful reframing of the experience, particularly if the interpreter is able to help make the join between the differing points of view.

Pezous (1992) has described the therapy space in such work as a transitional space between client and therapist in which cultural and other differences can be explored and a creation of a common culture (or perhaps narrative) can be created. The interpreter is seen as holding or representing this common view built up between the three parties. As Pezous concludes:

And while the quantity of information I received was less than I would have if I spoke Khmer, the quality of the therapeutic relationship benefited from the dynamic of these metacultural exchanges (authors' translation, 1992 p155).

Going further than this, Becker and Bowles (2001 p227) have described the three roles present in therapeutic work with an interpreter as symbolic of three timeframes, noting:

The triad offers a symbolic representation of the past, present and future as embodied by the newly arrived person, the interpreter who interprets the new language and culture and who has established him/herself in the new country, and the psychotherapist who symbolically characterizes permanence and security.

In fact, Thompson in her work with refugees and asylum seekers uses the image of a bridge, and will often ask clients where they see themselves in the transition across the bridge, if one side represents the country of origin and the other the country of exile or migration. This can be very helpful in exploring the process of exile but also seems to echo the image of Becker and Bowles, in that many clients report that they still feel they are on the

other side (home or first country side) of the bridge, while they tend to see the clinician as firmly located on the near side (second country side) of the bridge. The interpreter's position tends to be more nebulous, perhaps reflecting movement in the client that they have not yet recognised. Interpreters may be seen as somewhere on the bridge, or perhaps already well-positioned on the second country side. Exploring this with clients, and reflecting on any ideas they have about the place of the interpreter, can be informative. Both Tribe (1997) and Holder (2002) have reflected on the way in which the interpreter can be seen as a model for the client, showing that it is possible to survive leaving home and changing country, migration, finding work and even thriving in a new country of emigration or exile.

Gains in therapeutic work with traumatic experiences

Other gains in working with interpreters relate to the way in which work on traumatic material may be more helpfully managed in a three-way relationship.

Becker and Bowles (2001) have noted that it can feel safer for all three parties if work on trauma is shared more widely, perhaps helping to limit vicarious traumatisation.

The client's feelings and projections from torture may be of an intensity that is difficult to bear by one person... It is possible that the therapeutic space may be more safe and containing with two people. (2001 p227)

Similarly, Miller and colleagues (2005 p33) describe therapists they interviewed as saying:

'It was traumatizing... and having the interpreter there with you was so immensely comforting because you know that you could process it together'

and

'I was actually quite glad, very appreciative really, to have the interpreter there with me. It made the intensity of the client's reaction easier to sit with, and I was glad to have someone with whom to process the experience after the session ended'.

This helpful aspect provided by the interpreter thus relates both to the experience of the client, who faces a more powerful form of witnessing when two others hear their story of traumatic experience, and to the experience of the clinician, who feels safer and more able to contain what he or she hears as a result of sharing the experience of hearing with the interpreter. Having said that, there is a need to be mindful that the interpreter has no clinical training and may require additional support or debriefing to help them manage what they are hearing.

The clinician's use of language

A final but very important area in which working with an interpreter adds value is in relation to the clinician's approach to his or her own use of language. Once an interpreter is introduced, the way in which language is used, often without thinking, is thrown into sharp relief, often with very useful consequences. Raval (1996), for example, reports that participants in his study found that working with an interpreter enabled them to be more reflective about their interventions, something they found facilitative. Holder (2002) found that the clinicians she interviewed felt that they had become more alert to non-verbal communication as a result of working with an interpreter. In addition, she notes that clinicians described a very interesting process taking place as part of therapeutic work, which involved a joint struggle to find the right words between the three parties involved, underscoring the importance for all of developing a shared meaning (otherwise potentially taken for granted). Some of her participants felt that this had led them to develop a greater curiosity about how language is used and meaning co-created in therapy with any client.

All the time in therapy you're questioning and questioning and questioning... you may have to do that more if you're not sharing the same language or background and I think you probably do it more... What I find is I do it more now when I'm working with same language clients, so it's actually had a positive effect. (Holder, 2002 p52)

Other participants remarked on the way that work with an interpreter had led them to simplify the language used, re-assessing how much they needed the jargon

they used and what assumptions it might disguise. While doing this, they were led to make more use of oft-repeated phrases of the clients, thereby entering into their frame of reference more completely, or developing shared bilingual expressions and word uses in a more innovative fashion.

These observations of Holder (2002) seem to relate to the observations of Bot and Wadensjo (2004), who describe different views about how language functions that need to be considered when weighing up the impact of an interpreter on therapeutic work. They describe two views, the monological view of language, which sees meaning as fixed (and so potentially lost in the interchange of interpreting), and the dialogical view that:

meanings of words and expressions are understood as being partly established between people in interaction (Bot & Wadensjo, 2004 p357).

The authors point out that monological and dialogical processes are at work simultaneously in therapeutic work, but that 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 or misunderstood. On other occasions, there is a sense in which the message arrives with the other person which may not simply be about understanding of words. As the authors remark:

seen from a dialogical perspective, the words of the therapist and patient get their specific meaning in the intersubjective therapeutic reality (Bot & Wadensjo, 2004 p358).

Add an interpreter, and this is just a three-person interaction in which:

people can, although they might not understand the words of their interlocutor directly, nevertheless hear if the speaker hesitates, halts, changes intonation and so forth (Bot & Wadensjo, 2004 p361).

In the view of these authors, the interpreter will move between situations in which they are used as an interpreting machine and their personhood fades into insignificance, and other times when they are included in conversation as a fully-fledged participant. In both situations, meaning may be facilitated, but the use of the interpreter will be different. For these authors, the development of shared understanding in the therapeutic work can be described as a form of 'play', and this joyous and flexible quality is often reflected in the remarks of clinicians listed in Holder (2002), who appear to be enjoying their own curiosity about their use of language and the interplay of the three participants in therapy when an interpreter is present.

Similarly, we have experienced the use of co-reflecting about language, meaning and the use of an interpreter with clients as very instructive and illuminating, often accessing areas of clients that might otherwise not have come to light. Tribe describes her work with a client who had been brutally raped by several soldiers, and with an interpreter who was of the same nationality and gender as the client. Both had experienced extreme political unrest and a climate of fear in their shared country of origin, and both women had fled as refugees to Britain. When they began talking about the client's experience of rape, the interpreter found that she could not 'remember' the associated words in her own language. Rather than accepting the interpreter's view of this as a failure on her part, Tribe reports that they made use of the therapeutic space to talk about words that were so emotionally laden or associated with difficult feelings or experiences that they were difficult to recount, and it was accepted that in such cases it might literally not be possible to find the words in any language.

Why are clinicians unsure about using interpreters?

We hope that this paper has outlined some of the interesting ways in which interpreters can add importantly to therapeutic work. Given these observations, it seems important to end by thinking about what might be the reasons for the excessively dour and pessimistic slant of many writers on this subject.

Lack of exposure/experience in clinicians

In many cases, it may be that clinicians have limited experience of working with interpreters at the time they come to evaluate the challenges. Miller *et al* (2005), for

example, found that the therapists they interviewed reported discomfort when first working with clients and interpreters, but for most this initial discomfort faded and they saw the experience as enjoyable. Similarly, when evaluating the pushes and pulls of the three-way working relationship:

most therapists said that they did not necessarily find such reactions problematic if they were not too extreme and if the interpreter was able to recognize and address their emotional response (Miller et al, 2005 p34).

The therapists included in this research had to have worked with at least two clients and interpreters to take part, which may not appear to be many, but still they were able to reflect on both positive and negative aspects. It could be that there is a need for research with more experienced practitioners (Holder, 2002) rather than with those at the start of careers or less experienced in working with interpreters, who are more likely to stress the negatives.

In line with this, Kline, Acosta, Austin and Johnson (1980) report what appears to be an interesting bias in perception by psychiatric resident doctors treating Spanish-speaking patients. In this research, patients working through an interpreter reported relatively high rates of satisfaction with their appointments. In contrast, the resident doctors who worked with them were likely to see them as having had a poor experience of contact and to refer them onwards to 'overworked bilingual colleagues', rather than continuing to work with them through an interpreter. The authors argue that this reflects a projection on the part of the doctors, who feel that the experience is less satisfactory for their patients because of their own discomfort in working with interpreters. The authors conclude:

... we cannot escape the conviction that the therapists in our study did not understand that patients who requested interpreters wanted to return for second visits, felt understood and thought, or at least said, that their initial visit was helpful. This misjudgment seems to come not from crude anti-Hispanic prejudice but

from the difficulty we all experience in bridging cultural and linguistic barriers (Kline et al, 1980 p1533).

This echoes an observation made by Holder (2002), who refers to an:

over-reliance on bilingual paraprofessionals who may be making interventions which they are not qualified to carry out,

or Westermeyer (1990), who refers to clinicians assigning a status of 'junior clinician' to interpreters, obliging them to work well beyond their competence in carrying out assessment and treatment tasks in order to avoid the need to work with interpreters. Further, when obliged to work with interpreters, clinicians with more limited experience may only regard them as a 'necessary nuisance' getting 'in the way of their real clinical work' (Tribe, 1997), and may tolerate situations which make the work much more difficult, for example being obliged to work with different interpreters in work with the same client or failing to register the importance of the interpreter's gender, nationality or ethnic origin (Haenal, 1997).

Also noted in this regard has been the lack of experience of this work among clinical supervisors, something that is likely to translate into lack of support for clinicians with less experience. Haenal (1997) makes clear his view that clinical supervision should explore the relational aspects of three-way relationship by including the interpreter in its considerations, while Westermeyer (1990) stresses that supervisors themselves should be experienced in working with interpreters.

Lack of training and lack of support for interpreters

A further widely observed difficulty, and one likely to contribute to the pessimism of writers in the field, has been the variation in background, education and empathy of interpreters. Marcos (1979) found significant problems including omissions, additions and distortions of meaning when cross-checking interpreted diagnostic interviews where the interpreters were not experienced in psychiatric work. He recommends the use of experienced interpreters and the opportunity for

meetings before the session to explain how to interpret, as well as meetings post-session to explore the content and any impressions the interpreter may have gained of the client but not translated. In support of this, Farooq, Fear and Oyeboode (1997) found that use of an experienced interpreter did provide reliable data for diagnosis, suggesting that levels of experience are crucial for interpretation when specific information using monological terms of reference is required.

Some specific suggestions

Many authors have commented on the need to clarify the role of the interpreter in any work undertaken (Patel, 2003). This should be a point of discussion between interpreter and clinician prior to the start of sessions and may require considering what the client's ideas of the interpreter might be, given the structure of society in their home country, ideas about gender, class, age and other variables, as well as the political situation. This will lead to a sense of safety in the three-way relationship.

There is a clear need to avoid the 'splitting of the treatment team' into unhelpful two-way alliances. We have argued in a companion paper (Tribe & Thompson, submitted) that this may be best negotiated by building a slightly greater closeness between interpreter and clinician, and this idea is in tune with the observation of Becker and Bowles (2001) that the interpreters they interviewed stated that a good relationship with the therapist was vital for therapy to succeed. As these authors state:

psychotherapists can mirror the idea that most issues can be worked through to a healthy resolution,

helping interpreters to reflect on the feelings evoked in the work and demonstrating that the three-way relationship can work helpfully for all.

A number of writers have made suggestions about the kind of training needed by clinicians to prepare them for working effectively with interpreter. Tribe and Sanders

(2003) suggest the need to include guidance on how to brief interpreters and make choices about interpreting approaches, and how to consider the attachment between client and interpreter as well as that between client and clinician. They also suggest a possible curriculum for training interpreters and clinicians. Westermeyer (1990) goes so far as to suggest that clinicians should observe more experienced practitioners working with interpreters and that bilingual clinicians translate between patients and colleagues so that both can develop a sense of the complexities involved.

... one must learn to ask translatable questions and to educate, confront and interpret in translatable terms and statements
(Westermeyer, 1990 p746)

Miller and colleagues (2005) observe that interpreters working in the mental health field are set apart from interpreters in other settings by the combination of an ongoing relationship with clients, often over extended periods of time while working with highly charged, emotional material. As a result, they stress the need for relevant training, perhaps including significant information on the workings of psychological therapy and the dangers of alliances, as well as ongoing support. This call for training is echoed by a number of other writers (Becker & Bowes, 2001; Tribe & Sanders, 2003). Similarly, Haenal (1997) stresses the necessity of regular debriefings, immediately after the therapy session, and the desirability of the interpreter's regular attendance in a Balint¹ or supervision group. Such initiatives are particularly important given Lipton *et al's* (2002)'s qualitative investigation of the psychosocial consequences of work for interpreters in Western Australia. The authors describe the way in which interpreters' codes of ethics prevent any disclosure of the content of their work, effectively preventing them from ventilating or debriefing to anyone other than the relevant practitioner outside the therapeutic session. They stress the need to aid interpreters and the organisations representing them in developing guidance that allows for some exterior debriefing, with appropriate limits to confidentiality specified.

¹Balint group: working group of mixed background - medical doctors, therapists, social workers, nurses and others - report and share their experiences with their patients or clients in regular sessions under direction of a designated group leader. The aim of the group is to make evident the thoughts, feelings and value judgements of the helpers towards their clients, to prevent enmeshment and to provide an anxiety-free communication with clients (Balint, 1957).

Many writers have also commented on the way in which interpreting continues to be viewed as a low-status occupation. Drennan & Swartz (1999 p170) point out that:

while the tasks of interpreting can be seen as impossibly complex, the everyday routinisation of cross-cultural communication and the frequently low status of the interpreter in institutional contexts belie this.

This seems to us to hit an important nail on the head. Clinicians and the organisations they work for seek to use interpreters in a variety of ways, often believing they are well-positioned to inform therapeutic and medical work, act as advocates for disempowered patients and clients, instruct clinical teams on relevant cultural information and so forth, while receiving the lowest rates of pay and being accorded limited professional recognition. Granger and Baker (2003) report similar findings in a UK study. They note specifically the frustration of interpreters at not being accorded professional status or being paid in a way commensurate with their skills and expertise, as well as the lack of support and supervision to assist with the stressful nature of the job.

Perhaps linked with this, with regard to policy, Tribe and Thompson (2007) have asserted the need for each organisation to provide guidelines and clarify the habitual roles of interpreter and professional in all areas of work. Contractual arrangements can be made which explain how confidentiality should be managed by interpreters and the expectations existing on issues like interpreter advocacy. We would argue that this is an area too important to be left to the individual decisions of specific clinicians, and would urge organisations to begin engaging with recommendations for all their staff. This could both limit potentially unhelpful working practices and begin to address the marginalised status enjoyed by interpreters in many health and mental health care settings. In keeping with the approach of Holder (2002), such guidance should consider all aspects of mediated communication (for example written translation and communication in second or alternative languages).

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