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Therapists' and Interpreters' Perceptions of the Relationships When Working with Refugee Clients

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Therapists' and Interpreters' Perceptions of the Relationships When Working with Refugee

Clients

A Dissertation Presented

In Partial Fulfillment

Of the Requirements for the Degree

Doctor of Philosophy in Marriage and Family Therapy

By

Janet Robertson, M.A

December 11, 2014

Abstract

This dissertation consists of two articles focusing on foreign language interpreters in mental health. The first article is a literature review examining the existing research on mental health professionals working with foreign language interpreters while conducting therapy with refugee clients. After excluding articles that were not research studies and those that focused on physicians rather than therapists, 19 articles fit the search criteria. The majority of the articles that did not fall into the research category focused on recommendations and protocols for treatment. Those that did fit within the criteria were categorized into 5 main themes. Those themes were: effectiveness research, emotional influences, therapeutic alliance, role of the interpreter, and therapists' experiences of interpreter roles. The second article explored the interpreters' and therapists' perceptions of the triadic and dyadic relationships within the therapist-interpreter-refugee client system. A systemic lens was adopted to directly examine the question of how interpreters and therapists working with refugee clients experience the relationships among interpreters, therapists, and refugee clients in therapy. Three interpreters and three therapists were interviewed and four themes and nine subthemes emerged, all centered around a triadic relationship between the therapist, interpreter and client. This study revealed a circular process within the triadic system in which all of the members of the system influenced one another. It also revealed a reciprocal process in which both the therapist and the interpreter's perception of the other member's relationship with the client influenced the individual's feelings of effectiveness in therapy.

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Keene, New Hampshire

Department of Applied Psychology

December 11, 2014

WE HEREBY RECOMMEND THAT THE DISSERTATION BY

Janet A. Robertson

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Dedication Page

This dissertation is dedicated to all of the refugee families with whom I worked. They taught me so much about hope, resilience, and the importance of deep-rooted cultural values. I am forever changed from hearing their stories. I hope to continue to dedicate my work to improving mental health for all refugee families in the U.S.

Acknowledgment Page

I would like to thank my husband and partner, Jacob, who supported and encouraged me throughout my doctoral degree. His commitment to gender equality and justice in the world makes me happy and proud to be his spouse. He constantly holds onto the idea that I can accomplish the many challenges I face and this helps give me the confidence I need to achieve my goals.

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I would like to thank my brother, Michael, who is always ready to provide comic relief, but will give you his serious side in a heartbeat if needed. Thank you also to my younger sister,

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Foreign Language Interpreters in Mental Health: A Literature Review

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Abstract

The refugee experience of possible trauma and stress adapting to a new country suggests multiple mental health needs that could be addressed in therapy. Although refugees with limited English proficiency arrive in the U.S. with varying degrees of stress and life experiences, one common theme is their need for a foreign language interpreter. The lack of formal training available to both foreign language interpreters and mental health professionals means that the majority of their knowledge about working together in this setting is gained either through reading the literature and/or based in trial and error in the therapy sessions. The purpose of this literature search is to examine what research exists on mental health professionals working with foreign language interpreters while conducting therapy with refugee clients and what themes emerge across these studies. After excluding articles that were not research studies and those that focused on physicians rather than therapists, 19 articles fit the search criteria. The majority of the articles that did not fall into the research category focused on recommendations and protocols for treatment. Those that did fit within the criteria were categorized into 5 main themes. Those themes are: effectiveness research, emotional influences, therapeutic alliance, role of the interpreter, and therapists' experiences of interpreter roles.

Foreign Language Interpreters in Mental Health: A Literature Review

Each year, the United States government admits more than 50,000 refugees into the country with the highest number of resettlements occurring in 2009 at 74,854 (United States, 2013). Since 2007, 441,227 refugees have resettled in the U.S. According to the 1951 Refugee Convention, a refugee is defined as someone who:

> owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality, and is unable to, or owing to such fear, is unwilling to avail himself of the protection of that country (United Nations, p. 14).

Refugees in the U.S. not only experience persecution and fear before arriving in the refugee camps, they experience difficulties at all stages of resettlement that affect their mental health in the U.S., including multiple traumas and the disruption of social networks. The refugee camps themselves may include harsh living conditions and violence, while refugees in them experience uncertainty about their resettlement plans. After finally arriving in the United States, refugees are faced with multiple stressors, including possible loss of social status, unresolved concerns about family members left behind, adapting and acculturating to a new country, unemployment, and difficulties in language learning (Kirmayer et al., 2011). Many refugees do not speak English on arrival to the U.S., which is one of many barriers to accessing mental health resources. Once refugees enter psychotherapy, many of them need the assistance of a foreign language interpreter due to the language barrier. According to the U.S. Census Bureau (2010), 8.6% of the U.S population aged 5 years or older spoke English "less than very well" in the year from 2006-2008. This number has increased 80% from 1990 to 2010.

The refugee experience of possible trauma and stress while adapting to a new country suggests multiple mental health needs that could be alleviated with the use of therapy. Although refugees with limited English proficiency arrive in the U.S. with varying degrees of stress and life experiences, one common theme is their need for a foreign language interpreter in their health care sessions. The interpreters who work with refugees often have additional training in medical interpretation, but when it comes to mental health, very few interpreters have training and gain their knowledge of mental health interpretation from experience in the field (Searight & Searight, 2009). Many mental health professionals have advocated for increased training in mental health interpretation for interpreters (Searight & Searight, 2009; Tribe & Thompson, 2011) and have emphasized the unique demands of mental health interpretation. In the field of couples and family therapy, there is minimal, if any, training for therapists working with interpreters.

According to the American Association for Marriage and Family Therapy (2004), one of the core competencies of training programs must include therapists learning how to "deliver interventions in a way that is sensitive to special needs of clients (e.g., gender, age, socioeconomic status, culture/race/ethnicity, sexual orientation, disability, personal history, larger systems issues of the client)" (p. 4). This does not require that therapists learn how to work with foreign language interpreters and many couple and family therapy graduates leave their programs without ever being exposed to this skill. The lack of formal training available to both foreign language interpreters and mental health professionals means that the majority of their knowledge about working with interpreters and refugees is gained either through reading the literature and/or based in trial and error in therapy sessions. The literature serves as an important source for clinicians doing work with refugees. The purpose of this literature search is

to examine what research exists on mental health professionals working with foreign language interpreters in therapy with refugee clients and what themes emerge across the studies.

Method

A literature search was conducted using the PsychInfo and Medline databases. The following keywords were used: *Interpreter and refugee*, paired with *mental health, psychology, marriage and family therapy, psychiatry*, and *counseling*; and *foreign language interpreter*, paired with *mental health, psychology, marriage and family therapy, psychiatry,* and *counseling*. The search was limited to peer reviewed academic journal articles on research using quantitative and qualitative methodologies. After excluding articles that were not research studies and those that focused on physicians rather than therapists, nineteen articles fit the search criteria. The majority of the articles that did not fall into the research category focused on recommendations and protocols for treatment. Those that did fit within the criteria were categorized into five main themes. Those themes are *effectiveness research, role of the interpreter, therapists' experiences of interpreter roles, systemic lens, therapeutic alliance,* and *empathy*. Some articles fit into more than one category.

Recommendations and Papers

Some authors and therapists working in the field of mental health wrote papers on their experiences and provided guidelines for therapists working with foreign language interpreters. These articles are not listed within the results section because they are not considered studies, but are worth mentioning in this review. The majority of the papers are based in countries outside the United States (Björn, 2005; d'Ardenne, Framer, Ruaro, & Priebe, 2007; Darling, 2004; Dubus, 2009; Raval, 2005; Rousseau, Measham, & Moro, 2011; Tribe, 2009; Tribe & Keefe, 2009; Tribe & Lane, 2009; Tribe & Morrissey, 2004; Tribe & Thompson, 2011; Tribe &

Tunariu, 2009), with four papers focused on work within the U.S. (Bolton, 2002; Paone & Malott, 2008; Searight & Armock, 2013; Searight & Searight, 2009).

Increasingly, therapists are acknowledging the importance of interpreters demonstrating empathy and warmth towards clients in therapy rather than providing verbatim interpretation in session (Searight & Searight, 2009). In their recommendations for working with interpreters in mental health, Tribe and Morrisey (2004) describe a constructionist mode of interpreting where the interpreter is concerned with the meaning and feeling of words rather than strict verbatim interpretation. For this method to be effective, the therapist, interpreter, and client need to be aware of its use and the roles of the therapist and interpreter need to be clarified prior to therapy sessions.

The relationship between the interpreter and client is seen as an important source of trust. However, most authors recommend not using family members or friends of the clients as interpreters (Rousseau et al., 2011; Searight & Searight, 2009; Tribe, 2009; Tribe & Morrisey, 2004) as it creates issues in client comfort and confidentiality. Using the same interpreter for every therapy session is also recommended to increase client safety and trust in therapy. Therapists' use of technical language and specialist terminology, as well as proverbs and sayings, are generally not recommended as they are specific to the therapist's culture and not easily conveyed to clients. Pre-sessions with interpreters are a good way to clarify the working relationship and to brief the interpreter on the session content and goals (Searight & Searight, 2009). This avoids confusion of roles, especially when cultural issues emerge during the session.

During the session, the interpreter at times takes on the role of cultural broker. Clarifying this role beforehand makes it easier for the interpreter to interject as a cultural broker in session. Some authors recommend building in a period of time to de-brief with interpreters after the

sessions to clarify any cultural misunderstandings and assess available emotional supports for the interpreter (Searight & Searight, 2009; Tribe & Morissey, 2004; Tribe & Thompson, 2011).

In addition to those authors who have provided recommendation and guidelines, some therapists have written papers about their personal experiences working with foreign language interpreters and the challenges involved (Bolton, 2002; Darling, 2004; Rousseau et al., 2011). These challenges include establishing trust with the client and fear about confidentiality for the client in a small community (Bolton, 2002). Bolton (2002) recognizes the influence of a strong interpreter-psychiatrist relationship on the psychiatrist-client relationship and the tendency of either the psychiatrist or the patient to feel excluded from either dyad. Rousseau et al. (2011) describe some of the challenges in diagnosing mental health in children and intervening in times of family crisis. They recommend never using children as interpreters, not relying on parents' assessment of child linguistic development, keeping the same interpreter for every session, and holding pre-session meetings with the interpreters to discuss goals and establish a working alliance.

Dubus (2009) and Raval (2005) conceptualize this working alliance as one in which the therapist and interpreter work together as a collaborative team in therapy. Dubus (2009) views the interpreter as a co-therapist, whose tasks include making assessments, acting as a cultural broker, and developing a therapeutic alliance with the client. This model stemmed from Dubus's (2009) recognition of the interpreter's expertise and the therapist's limitations in therapy involving the use of culturally appropriate interventions. The interpreter in this model summarizes the client responses rather than interpreting verbatim, making room for the therapist to focus on nonverbal communication from the client. It also enables the therapist to maintain a "meta-position" (p. 334) in session where they observe what information is prioritized, the

content of the client's response, and their own observations of the client's nonverbal communication. An important consideration in this approach is the wellbeing of the interpreter. De-briefing is important at the end of every session as well as ongoing supervision for both the therapist and the interpreter.

This sensitivity to the interpreter's emotional response is viewed as an important component of an effective co-worker relationship between interpreter and therapist (Raval, 2005). Raval (2005) conceptualizes this co-worker relationship slightly differently from Dubus (2009), although they share many similarities. She views the interpreter as a bilingual co-worker rather than a co-therapist in therapy. Raval (2005) stresses the importance of discussing the multiple roles of the interpreter beforehand to avoid confusion and to provide a context in which the therapist and interpreter works. The interpreter's roles include acting as a translator, advocate, cultural broker and consultant, intermediary, community worker, and co-facilitator. This model also includes briefing and de-briefing to plan and finalize roles that each worker will undertake. Raval (2005) acknowledges that this collaborative approach is difficult for some therapists to establish due to a lack of training and support, poor management of the complex process of communication, interpersonal conflicts, and the emotional impact of the work. She offers guidelines on how to manage these challenges and highlights the need for therapists and bilingual co-workers "to take a collaborative, pragmatic, respectful, versatile, and reflective approach to their work with families" (p. 212).

Results

Effectiveness of Interpreters in Therapy

There have been some researchers who have studied the effectiveness of using interpreters in therapy (Brune, Eiroá-Orosa, Fischer-Ortman, Delijaj, & Haasen, 2011;

d'Ardenne, Ruaro, Cestari, Fakhoury, & Priebe, 2007; Jensen, 2013; Kline, Acosta, Austin, & Johnson, 1980; Mofrad & Webster, 2012; Price, 1975; Schweitzer, Rosbrook, & Kaiplinger, 2013). The early studies are rooted in the field of psychiatry (Kline et al., 1980; Price, 1975), while the majority are rooted in psychotherapy using either a psychodynamic (Brune et al., 2011; Schweitzer et al., 2013) or cognitive-behavioral approach (d'Ardenne et al., 2007; Jensen, 2013; Mofrad & Webster, 2012). There are no empirically-based research studies on the effectiveness of foreign language interpreters in the field of couples and family therapy.

Psychiatry. The earliest study by Price (1975) examined the problems associated with the use of interpreters in psychiatric practice. Price (1975) used data from three doctors and three interpreters. He found that important information was at times omitted from the conversations resulting in the misdiagnosing of patients. The mistakes in interpreting increased with patients with more severe (sometimes psychotic) symptoms. Price (1975) also noted that doctors misjudge the language competencies of interpreters and recommends a thorough assessment of this aspect before continuing with a particular interpreter. At the time of this study, recommendations for interpreters included minimizing personal involvement, respecting confidentiality, and developing a thorough knowledge of the client's culture. This lack of personal involvement of the interpreter has more recently been refuted as a myth and one that is almost impossible to attain (Penn & Watermeyer, 2012). Price (1975) acknowledges that culture plays a role in distinguishing between cultural beliefs or symptoms of delusion, but did not include culture or the therapist-interpreter relationship as possible variables in the study.

The second study on effectiveness aimed to evaluate therapy and communication effectiveness when interpreters were present (Kline et al., 1980). The study involved 21 Spanish speaking patients who used interpreters during the initial interview, 40 Spanish bilingual patients

who did not use interpreters, and 16 second-year resident psychiatrists. They used a 17-item questionnaire that was given to patients immediately after their initial intake interview. The residents were given a questionnaire on their emotional reactions to the interview. The patients who were interviewed with interpreters were generally more satisfied with the process, whereas those patients who did not use interpreters were generally less pleased with the interview process. More than twice as many patients who used interpreters thought the doctor helped them during the initial interview. The residents' responses were quite different than the patients' in that they thought the patients who were interviewed in English felt more appreciated, more eager to return, and better understood than those interviewed with an interpreter. The residents also indicated that they felt more comfortable with interviewing patients in English and felt they were more helpful to patients when an interpreter was not present. The interpreter's voice was missing from this study and would have given some insight into the contrasting responses of the patients and residents.

Psychodynamic therapy. There are two effectiveness studies involving psychodynamic approaches, one of which is a case study (Brune et al., 2011; Schweitzer et al., 2013). A more recent study explored the effectiveness of using interpreters in therapy using a sample size of 190 patients, of whom 48.9% were treated with the use of an interpreter (Brune et al., 2011). This quantitative study used the Hamilton Rating Scale for Depression to measure symptom improvement and the Clinical Global Impression to measure the treatment outcome. The researchers found that there were no significant differences between groups of patients who used interpreters and the groups of patients who did not, even though the patients who used interpreters tended to experience more difficult psychosocial circumstances.

Schweitzer et al. (2013) conducted a case study of a 52-year-old Cantonese man with depression using a psychodynamic approach. In their paper, they explored transference and countertransference and how the relationship between therapist and client changes to a more complex triadic relationship when an interpreter is present. The interpreter was seen as having a role in the containment necessary for a safe therapeutic environment and the client seemed to appreciate the empathy and interest she brought into the room. The therapist also had emotional responses to the interpreter as she responded to the interpreter-client relationship. They concluded that the therapeutic effectiveness of transference and countertransference in a triadic therapeutic relationship can be achieved and supervision plays an important part in the process for both therapists and interpreters. Similar to Dubus (2009) and Raval (2005), they recognize the need for supervision for the interpreter working in mental health to work through issues that come up for them in therapy sessions.

Cognitive Behavioral Therapy. Three studies examined the effectiveness of working with interpreters while using a cognitive-behavioral approach (d'Ardenne et al., 2007; Jensen, 2013; Mofrad & Webster, 2012). Similar to the patients who were more satisfied in treatment when interpreters were present (Kline et al., 1980), d'Ardenne et al.'s (2007) study revealed that the refugee patients who used interpreters improved more than those who did not require one in therapy. D'Ardenne et al. (2007) compared three different patient groups: those requiring interpreters, those not requiring interpreters, and non-refugee English speaking patients. All three groups were experiencing symptoms of post-traumatic stress disorder (PTSD) and all three groups were treated using cognitive-behavioral therapy. D'Ardenne et al. (2007) used the Impact of Events Scale, the Beck Depression Inventory and the Manchester Short Assessment of Quality of Life to measure patient outcomes. Although all three groups improved, those refugee

patients who used interpreters had proportionally more improvement than the refugees who did not require interpreters.

One case study of a therapist working with an interpreter using cognitive-behavioral therapy with a 35-year-old Middle Eastern woman focused on treating depression and a simple phobia (Mofrad & Webster, 2012). During the sessions, the therapist found it difficult to interrupt at times and did not feel in control of the agenda of treatment during those times. The therapist found that the interpreter brought many advantages to the treatment, such as the communication and understanding of cultural differences. The disadvantages included the risk for bias and lost information, and the increased time and complexity involved in working with an interpreter. Through the use of assessment tools throughout treatment, they found an improvement in symptoms and highlighted the importance of the therapist remaining humble and open to learning when working with an interpreter.

While Mofrad and Webster (2012) described the advantages of using an interpreter in treatment, the use of the interpreter in Jensen's (2013) case study was not acknowledged in the article. Jensen (2013) reported on using emotional processing and narrative exposure therapy with a 60-year-old Iraqi refugee with chronic PTSD and depression. Although Jensen (2013) reports using an interpreter in the sessions with this patient, there is no mention of how the interpreter was used. The patient in this study experienced improvement in a short period of time (26 one hour sessions) and a 66% reduction in anxiety symptoms as measured by the Beck Anxiety Inventory and a 63% reduction in PTSD symptoms as measured by the PTSD Symptom Scale-Self Report. The symptoms increased slightly at 3 months post-treatment and decreased significantly at 12-month post-treatment. Jensen (2013) reports preliminary evidence that

exposure therapy can be used with refugees who experience PTSD symptoms with the assistance of a foreign language interpreter.

Role of Interpreter in Therapy

Some researchers have studied the role of interpreters in therapy and the effect they have on the therapeutic process (Becher & Wieling, 2014; Engstrom, Roth, & Hollis, 2010; Miller, Martell, Pazdirek, Caruth, & Lopez, 2005; Mirdal, Ryding, & Essendrop Sondej, 2011; Penn & Watermeyer, 2012; Raval, 1996; Raval & Smith, 2003; Yakushko, 2010). In contrast to the studies on effectiveness, these researchers used qualitative approaches and focused on the experiences of interpreters and therapists working together in sessions. Of the seven studies examined here, four included interviews with interpreters (Becher & Wieling, 2014; Miller et al., 2005; Mirdal et al., 2011; Raval, 1996) and three focused exclusively on the therapists' experiences (Engstrom et al., 2010; Raval & Smith, 2003; Yakushko, 2010). Two researchers took on a systemic lens while conducting the research (Becher & Wieling, 2014; Raval, 1996), which was grounded in the researchers' backgrounds in family therapy.

Miller et al. (2005) explored the impact of interpreters on the therapy process, the perceptions of the interpreter's role in the therapy relationship, the impact on the interpreter's well-being, the challenges involved, and recommendations for interpreter training. The study was a phenomenological inquiry using semi-structured interviews of 15 therapists and 15 interpreters. The participants were from five different states across America and 13 of the interpreters were Eastern European refugees. Two main themes emerged from the study, the impact on the therapeutic alliance and complex emotional reactions. The therapist reactions were mostly positive. There were some therapists who felt confused about the interpreter's role and frustrated by the interpreter occasionally incorrectly interpreting client responses. Some of

the therapists also indicated feelings of self consciousness by having an interpreter witness their therapeutic work. The interpreter reactions mainly involved the emotional impact of hearing client stories. Although there was an emotional impact, the interpreters described the stress occurring briefly in the beginning of therapy and decreasing over time. In terms of hiring and training, only three of the interpreters had received specific training in mental health interpretation, which is consistent with the concerns of other researchers in the field (Searight & Searight, 2009).

Mirdal et al. (2011) explored the curative and hindering factors present when working with refugees and interpreters in therapy. The researchers selected four experienced psychologists and asked them to identify their two most successful refugee cases and their two least successful refugee cases. The researchers then interviewed the psychologists, interpreters and clients involved in the sixteen therapy cases. Through interviewing the participants, they found one of the curative factors to be the triadic relationship among the client, therapist, and interpreter. All three parties involved in the study highlighted this relationship as one of the most important pieces in therapy. Mirdal et al. (2011) note that the role of interpreter has been largely neglected in the psychology literature, emphasizing the need for a study exploring the nature of these relationships in therapy.

Penn and Watermeyer (2012) analyzed the small side conversations that take place between foreign language interpreters and clinicians in South Africa. This study was not exclusive to therapists, but involved a child psychiatry clinic as one of the settings in which these side conversations took place. They distinguished big talk from small talk in that big talk was related to services and care, and small talk was social in nature and helped to align the interpreter and client. The more successful triadic working relationships among interpreters, therapists, and

clients included interpreters in more fluid roles. This small talk within the fluid role led to trust between the interpreter and client. Penn and Watermeyer (2012) view these instances of small talk and trust as evidence that interpreting information verbatim is unrealistic and it is a myth that an interpreter can remain neutral in these interactions.

Therapist's Perspective

Yakushko (2010) completed a phenomenological inquiry into the experiences of therapists working with clients requiring interpreters. The researcher interviewed eight therapists on the challenges, benefits, and needs of clinicians in these settings. The two overarching themes that emerged focused on the training and personalities of both therapists and interpreters. They identified the importance of therapists remaining humble, flexible, patient, and open to learning. The therapists in the study emphasized the importance of interpreters remaining empathic, psychology-minded, and having high interpersonal skills. The therapists also highlighted the need for training in diversity and multicultural issues for therapists, and training in mental health basics and transference for interpreters. The therapists in this study recognized the importance of keeping the same interpreter for each therapy session and recognized the connection between the individual and client as being unavoidable in small communities.

Another phenomenological inquiry focusing on the therapists' experiences working with interpreters was done by Engstrom et al. (2010). Ten mental health providers were interviewed in this study using in-depth, semi-structured interviews. Engstrom et al.'s (2010) research question focused on the ways in which interpreters affect the clinical process. The themes that emerged were the interpreter's effect on communication and clinical practice. The theme of communication included the use of interpreters as cultural brokers, the interpreters' inaccurate interpretations of client responses, the occasional discomfort interpreters sometimes feel

regarding the clinical questions, and the inappropriate match between client and interpreter. The subthemes that emerged under the theme of clinical practice included establishing relationships among therapists, clients, and interpreters, and the interpreters' complex emotional reactions.

Communication and clinical practice emerged as themes in another study on therapists' experiences working with interpreters (Raval & Smith, 2003). Raval and Smith (2003) interviewed nine child and adolescent mental health practitioners. They explored potential changes in communication, the content of family responses, the effect of interpreters on the therapy process, and the theoretical frameworks from which therapists draw when interpreters are involved. Similar to Engstrom et al. (2010), communication emerged as a main theme in this study, including possible inaccuracies in interpretation; however, in this study, the participants discussed language and its impact on the therapeutic alliance. The therapist participants also described a change in the style of their questioning to simplify their interventions and adapt to both the interpreter's presence and the cultural needs of the client. Raval and Smith (2003) also identified the role ambiguities and power differentials felt by the therapists within the therapist-interpreter relationship. The role confusion created feelings of disempowerment for both therapists and interpreters. These feelings of disempowerment were seen in sessions where the therapists wanted more input from interpreters, but at the same time felt uncomfortable with the interpreters' unsolicited interjections. The power differentials were looked at in more depth by Becher and Wieling (2014) who explored culture and power within the therapist-interpreter relationships.

Systemic Lens

This study by Becher and Wieling (2014) is the most recent study on therapists and interpreters working together in mental health and one of two studies (Becher & Wieling, 2014;

Raval, 1996) incorporating a systemic framework. They interviewed seven therapists and seven interpreters and examined how their relationships were affected by elements of power and privilege. They acknowledge the importance of a triadic relationship among therapists, interpreters, and refugee clients, which is heavily influenced by culture and power. The researchers used an ethno-culturally informed qualitative procedure and identified three themes: interpreters speaking out, the relationship matters, and who has the power. The therapists' ambiguous feelings around unsolicited interpreter interjections in session emerged again in the study done by Becher and Wieling (2014). The researchers conceptualized this as "silencing" (p. 4). The therapists' lack of understanding of the interpreters' roles as cultural brokers affected the interpreters' abilities to fulfill these roles in session. The therapists in this study identified the power differentials in the therapist-interpreter relationship, whereas only a few interpreters recognized the power they hold in therapy.

One other study explored the impact of interpreters on the therapy process through a systemic lens (Raval, 1996). Raval (1996) used a questionnaire to survey 12 therapists working in London, England. The therapists surveyed worked in a multidisciplinary setting in child mental health. Raval (1996) also interviewed one Bangladeshi interpreter working in the same setting as the therapist participants. Raval (1996) explored how therapists are affected by the use of interpreters in therapy. She wanted to know how the therapist's role was affected, how the content of the family sessions was influenced, and the extent to which the families could talk about culture and race with an interpreter present. Several themes emerged from the questionnaires including the enhancement of or limitation to the therapist's work, the content of the therapy sessions, the effects on the therapeutic style of the therapist, and the discussion of cultural differences in session. The interpreter who was interviewed for the study shared her

perspective on the topics as well. She thought she was able to help the family become more comfortable with the content of the sessions by facilitating a connection between the family and the therapist. She occasionally perceived the therapist as experiencing a loss of authority or feeling threatened by the interpreter-client relationship. Similarly to Yakushko (2010), the interpreter viewed greater flexibility as an enhancement to her work and a more limited interpreter role as limiting the therapy process. She also identified the clients' increased comfort in session as influenced by the close interpreter-client relationship.

Therapeutic Alliance

There has been one study done specifically on the interpreter's effect on the therapeutic alliance (Boss-Prieto, de Roten, Elghezouani, Madera, & Despland, 2010). Boss-Prieto et al. (2010) explored this in their preliminary study on the therapeutic alliance in a cross cultural triadic setting. The researchers used a survey consisting of six dimensions of therapeutic alliance: help, understanding, collaboration, trust, agreement on goals, and agreement on tasks. The participants consisted of nine clients (all Albanese), seven therapists, and five interpreters (all Albanese). The participants were asked to share their meanings of the term, alliance, and then evaluate the six dimensions of alliance on a Likert-type scale. The researchers then looked at the differences in alliance between each dyadic relationship of client-therapist, client-interpreter, and therapist-interpreter. They found that the interpreters' ratings of alliance were always closer to the clients' ratings than to the therapists' ratings. Boss-Prieto et al. (2010) inferred that the therapists' ideas on alliance may be more intellectual than concrete and the interpreters' role in the alliance is reflective of their central role in the triad.

Empathy

Empathy and emotional reactions of both therapists and interpreters have been explored in multiple ways in the literature (Doherty, MacIntyre, & Wyne, 2010; Hsieh & Hong, 2010; Pugh & Vetere, 2009). Pugh and Vetere (2009) explored mental health professionals' experiences of empathy when working with interpreters in therapy. This was a qualitative study using semi-structured interviews with ten therapists. The researchers explored four interest areas: experiences of empathizing with clients using interpreters, potential changes or differences in empathy when an interpreter is present, challenges or obstacles to empathy, and the empathic benefits of using an interpreter. They identified four main themes that emerged from the interviews: (a) the effects of translation upon empathic dialogues with client; (b) the changes in empathic communication and the difficulty in evaluating client's reception of empathy; (c) the effects of shared cultures and cultural differences within the three dyads upon empathy; and (d) the opportunities for interpreters to enrich the professional's understanding of the client. Pugh and Vetere (2009) point out that the more traditional understanding of empathy stemming from the liberal-humanist school of thought tends to centralize the professional and may be less transferable to work with interpreters. They identify the constructionist models of empathy to be potentially more effective in working with interpreters in mental health.

When researching the interpreter's influence on empathy in the therapeutic alliance, it is important also to look at how they are affected by the emotions in the therapy room. Doherty et al. (2010) acknowledge this by studying the emotional effects and the specific challenges of mental health interpreting for interpreters. Their research involved 18 foreign language interpreters with a mean of 4.8 years of interpreting in mental health. They explored the presence, nature, and degree of emotional distress, as well as coping strategies used by the interpreters. They also gathered the views of interpreters on potential factors that would support

their work in mental health. Fifty-six percent of the participants reported some emotional

distress and 67% reported finding it difficult sometimes to put the distress out of their minds.

The aspects of the interpreters' work that they found most distressing included not being briefed

in advance of the therapy sessions and working with clients who became distressed in sessions.

Reminding themselves of the importance of the work and thinking through what they heard in

session were the most commonly described coping strategies used by the interpreters in the

study.

When interpreters are affected emotionally by clients' stories in therapy, they may be

more inclined to step in and support clients. Hsieh and Hong (2010) studied providers' views on

interpreters offering emotional support to clients in various settings. They completed a grounded

theory study involving 26 interpreters and 39 providers. Of the 39 providers in the study, seven

were mental health clinicians in a healthcare setting. The themes that emerged were not

separated by expertise and so it is difficult to distinguish between therapist and physician

responses. One theme identified as exclusive to therapists was the risk to therapeutic objectives.

Some of the therapists in the study were concerned about interpreters bonding with the patients

in ways that could hinder the therapeutic process. Their concern was related to the patient

creating a stronger relationship with the interpreter than with the provider, and that this strong

relationship could potentially block the therapeutic function of the alliance between therapist and

client.

Conclusion

As more refugees resettle in the U.S., the need for effective therapy with them becomes

paramount. Therapists' knowledge of working with interpreters in mental health is central to the

outcome of therapy for refugees. The lack of training for both therapists and interpreters in

mental health means that their knowledge of working together in sessions is gained from their direct experience in the field or the studies in the literature. Tribe and Tunariu (2009) advocate for training to be part of the core curriculum for health professionals. This training is missing from the core competencies in couples and family therapy programs. In addition, the voices of couples and family therapists are absent in the literature. Therapists who hope to gain knowledge from the literature will be faced with multiple perspectives and recommendations. Some recommendations are consistent throughout, while others vary based on the researcher's theoretical orientation.

The research on effectiveness includes only four empirical studies, two of which were written over thirty years ago. Price's (1975) early study provided a framework for therapists to begin to look at how interpreters affect their work, but included a small sample size of three interpreters and three psychiatrists. Kline et al. (1980) provide therapists with a better understanding of the interpreter-client relationship. They also begin to shed light on the effects of the interpreter-client relationship on therapeutic outcomes. Almost thirty years later, Brune et al. (2011) and d'Ardenne et al. (2007) and found similar results in that refugee clients in therapy who required the assistance of interpreters demonstrated improvement in their mental health symptoms. In some cases those refugee clients showed greater improvement than the refugee clients who did not require interpreter assistance in therapy.

One common theme that emerged in the effectiveness studies was the relationship between the interpreter and client. The case studies provide further evidence into the importance of the interpreter-client relationship and its effect on the outcome of therapy. The interpreter-client relationship was mentioned in Schweitzer et al. (2013) and Mofrad and Webster (2012). Both therapists in these case studies mentioned the tendency of therapists to feel excluded from

this close interpreter-client relationship. Although research is continuing to evolve in this area, all seven studies on effectiveness demonstrated the therapist's ability to provide effective therapy to clients who required the assistance of foreign language interpreters. There is a need for more empirical studies examining the relationship between treatment outcomes and the triadic relationship among therapists, interpreters, and clients.

All three studies on the role of the interpreter in therapy contain the theme of the therapeutic alliance and how the alliance between the therapist and client is influenced by the presence of an interpreter. Miller at al. (2005) identified some therapists' feelings of self-consciousness when they had an interpreter in the therapy room. This feeling is similar to those identified in the case studies written by Schweitzer et al. (2013) and Mofrad and Webster (2012), where therapists acknowledged feeling excluded from the interpreter-client relationship.

The dyadic portions of the therapist-interpreter-client triad were isolated and mentioned by multiple therapist and interpreter participants in the studies (Boss-Prieto et al., 2010; Engstrom et al., 2010; Hsieh & Hong, 2010; Miller et al., 2005; Penn & Watermeyer, 2012; Raval, 1996; Raval & Smith, 2003; Yakushko, 2010). Mirdal et al. (2011) were the only researchers who examined the triad when looking at curative and hindering factors in therapy. Yakushko (2010) identified the inevitable relationship that builds between the interpreter and client in small communities. This provides further evidence for Penn and Watermeyer's (2012) idea that the interpreter cannot remain exclusively neutral in therapy. This establishment of the interpreter-client relationship was also seen in Engstrom et al.'s (2010) study where therapists described the potential mismatch between interpreter and client in therapy. The complex emotional reactions of the interpreter emerge again in this study adding to the body of literature already identifying this as an area where supervision could play an important role. The

unavoidable relationship that emerges (Penn & Watermeyer, 2012; Yakushko, 2010) coupled with the positive impact of the relationship on the therapeutic outcome (Brune et al., 2011; d'Ardenne et al., 2007; Kline et al., 1980) suggests that it would benefit therapists to embrace this relationship rather than attempt to create a stronger relationship with the client than the client has with the interpreter. It would be more effective for the triadic relationship as a whole to be strengthened to increase the comfort of all members of the therapist-interpreter-client triad.

The three studies on empathy and emotional reactions center around the interpreter's role in the empathic process in therapy. The therapists in Pugh and Vetere's (2009) study acknowledged the difficulties in reading clients' empathic responses due to cultural and communication barriers, but also recognized the interpreters' roles in enriching that understanding for therapists. This led the researchers to discuss a more systemic view of empathic responses in therapy, where interpreters are part of the process rather than barriers to the therapist-client relationship. The therapists in Hsieh and Hong's (2010) study were concerned about the strong relationships that existed between the interpreters and clients and viewed these as having potentially negative effects on the therapeutic outcome. These therapists are not alone in their concerns, although previous research on effectiveness has shown more positive therapeutic outcomes when the interpreter and client relationship is strengthened.

The amount of evidence pointed towards a strong interpreter-client relationship suggests a need for therapists to move away from viewing interpreters as outside of the therapeutic alliance. The interpreters' shared cultural experiences with clients and their interpretation of client distress makes this relationship unavoidable. The therapists' feelings of discomfort about a strong interpreter-client relationship are related to fears about its influence on transference and

counter transference in therapy. Family therapists' views on triads and the valuing of multiple perspectives in therapy may bridge this gap in the research.

Therapists taking a more humble and respectful approach could allow for more space for the interpreter to share his or her expertise. This coincides with Becher and Wieling's (2014) concept of "empowerment and silencing" (p. 4). For both therapists and interpreters to feel empowered enough to share knowledge and build relationships, they need to be able to clarify roles and be open to new knowledge. This openness and clarification can only be achieved if the relationship between the interpreter and client is embraced rather than feared. Researchers need to continue to be curious and creative about the most effective ways for therapists to work with interpreters in therapy. This research will help therapists and interpreters develop productive coworker relationships and as a result provide quality care to refugee clients in therapy.

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Table 1

Literature Review Table Including Articles Arranged by Date of Publication

APA Citation	Participants	Study Information	Central Findings
Becher, E. H., & Wieling, E. (2014, August 4). The intersections of culture and power in clinician and interpreter relationships: A qualitative study. *Cultural Diversity and Ethnic Minority Psychology.* Advance online publications. http://dx.doi.org/10.1037/a0037535	7 clinicians 10 interpreters	Qualitative study examining how elements of power and privilege impact relational dynamics between interpreters and clinicians	Themes: 1. Interpreters speaking out 2. The relationship matters 3. Who has the power
Boss-Prieto, O. L., de Roten, Y., Elghezouani, A., Madera, A., & Despland, J. (2010). Differences in therapeutic alliance when working with an interpreter: A preliminary study. *Schweizer Archiv für Neurologie und Psychiatrie, 161,* 14-16.	9 clients 7 therapists (psychologists, psychotherapists, psychiatrists) 5 interpreters	Preliminary quantitative study analyzing the six dimensions of the therapeutic alliance in a cross cultural triadic setting.	Alliance meaning: 29.3% chose dimension of nurturing and 23.4% chose relationship (23.4%) Interpreter's rating of alliance was almost always closer to client's rating than to the therapist's.
Brune, M., Eiroá-Orosa, F. J., Fischer-Ortman, J., Delijaj, B., & Haasen, C. (2011). Intermediated communication by interpreters in psychotherapy with traumatized refugees. *International Journal of Culture and Mental Health, 4,* 144-151. doi:10.1080/17542863.2010.537821	190 patients (48.9% treated using interpreter)	Quantitative study exploring effectiveness of treatment when using an interpreter	When controlling for other factors, found no significant difference between groups.
d'Ardenne, P., Ruaro, L., Cestari, L., Fakhoury, W., & Priebe, S. (2007). Does interpreter-mediated CBT with traumatized refugee people work? A comparison of patient outcomes in East London. *Behavioural and Cognitive Psychotherapy, 35*, 293-301. http://dx.doi.org/10.1017/S1352465807003645	44 refugee patients requiring interpreters 36 refugee patients not requiring interpreters 48 non-refugee patients	Quantitative study comparing routine clinical outcomes of 3 groups of PTSD patients receiving CBT.	All 3 groups improved. Refugees with interpreters had proportionally more improvement than refugees without interpreters
Doherty, S. M., MacIntyre, A. M., & Wyne, T. (2010). How does it feel for you? The emotional impact and specific challenges of mental health interpreting. *Mental Health Review Journal, 15,* 31-44. http://dx.doi.org/10.5042/mhrj.2010.0657	18 foreign language interpreters	Mixed methods study exploring presence, nature, and degree of emotional distress related to occupation of mental health	56% reported some emotional distress 67% sometimes found it hard to put distress out of their minds 23% continued to think of client problems for several hours or days Challenging aspects were

APA Citation	Participants	Study Information	Central Findings
		interpreting.	interpreter-client, interpreter-therapist relationship; linguistic, cognitive, and emotional demands; boundary issues; risk. 78% said not being briefed before the session was a difficult aspect of their work

Engstrom, D. W., Roth, T., & Hollis, J. (2010). The use of interpreters by torture treatment providers. *Journal of Ethnic and Cultural Diversity in Social Work, 19,* 54-72. doi:10.1080/1531320 0903547749	10 mental health providers (SW, MFT, Psy.D.)	Qualitative study exploring ways in which interpreters affect clinical process.	Use of interpreters affects areas of communication and clinical practice.
			1. Communication
			  a. cultural brokers
			  b. inaccurate interpretation
			  c. interpreter discomfort with material
			  d. inappropriate client-interpreter match
			  e. inconsistency
			2. Clinical Practice
			  a. establishing relationships
			  b. interpreters' complex emotional reactions

Hsieh, E., & Hong, S. J. (2010). Not all are desired: Providers' views on interpreters' emotional support for patients. *Patient Education and Counseling, 81,* 192-197. http://dx.doi.org/10.101 6/j.pec.2010.04.004	26 interpreters
	
	39 health care providers (8 ob/gyn, 7 ER med, 11 oncology, 6 nursing, 7 mental health)
		Part of a larger qualitative study examining roles of medical interpreters. Explores interpreters' understanding and practice of their roles	Four major themes
			1. Emotional support is embodied through physical presence
			2. To be human, but also professional
			3. Extension to provider's care
			  a. establishing effective provider-patient communication
			  b. culturally sensitive care
			4. Potential risk to quality of care
			  a. to provider-patient bonding
			  b. to therapeutic objectives
			  c. to malpractice litigation

Jensen, B. S. (2013). Treatment of a multitraumatized tortured refugee needing an interpreter with exposure therapy. *Case Reports in Psychiatry, 2013,* 1-8. doi:http://dx.doi.org/10.1155/201 3/197323	60-year-old male Iraqi refugee in treatment for chronic PTSD and depression in Denmark.	Case study involving therapist using emotional processing theory, the cognitive model of PTSD and narrative exposure therapy through an interpreter	Improvement achieved in short period (26 one hour sessions). 3 month follow-up, patient reported increase in symptoms to mild PTSD and moderate depression, however anxiety and subjective experiences of PTSD remained low.

APA Citation	Participants	Study Information	Central Findings
			6 and 12 month follow-up reduction in symptoms. PSS-SR scores reduced by 66% from pre- to post treatment. BAI scores reduced by 63% pre- and post-session.
Kline, F., Acosta, F. X., Austin, W., Johnson, R. G. (1980). The misunderstood Spanish-speaking patient. *The American Journal of Psychiatry, 137,* 1530-1533. doi:10.1177/136346158101800414	21 Spanish speaking patients 40 Spanish bilingual patients 16 second year psychiatric residents	Quantitative study exploring the experiences of Spanish speaking patients with and without an interpreter. Questionnaire evaluating therapy and communication effectiveness	Patients interviewed with interpreters were generally better satisfied with clinic, those without interpreters were generally less pleased. Nearly twice as many patients using interpreters thought doctor helped them in initial interview. In contrast, residents thought patients interviewed in English felt more appreciative, more eager to return, and felt better understood.
Miller, K. E., Martell, Z. L., Pazdirek, L., Caruth, A., & Lopez, D. (2005). The role of interpreters in psychotherapy with refugees: An exploratory study. *American Journal of Orthopsychiatry, 75,* 27-39. http://dx.doi.org/10.1037/0002-9432.75.1.27	15 therapists 15 interpreters	Quantitative study on the effect of interpreters on the therapy process.	Themes: Impact on therapeutic alliance, complex emotional reactions.
Mirdal, G. M., Ryding, E., & Essendrop Sondej, M. (2011). Traumatized refugees, their therapists, and their interpreters: Three perspectives on psychological treatment. *Psychology and Psychiatry: Theory, Research and Practice, 85,* 436-455. doi:10.1111/j.2044-8341.2011.02036.x	4 psychologists 16 patients 8 interpreters	Qualitative study on curative and hindering factors in therapy with refugee clients.	Curative factors: relationship between patient, interpreter, therapist; ordering chaos and finding meaning; psychoeducative interventions and counseling; events external to the therapeutic process and living conditions; transdisciplinary interventions and coordination. Hindering factors: severe comorbidity and lack of motivation on part of patient; diverging goals and overinvolvement or underinvolvement on the part of therapists and interpreters; factors external to therapy
Mofrad, L., & Webster, L. A. D. (2012). The treatment of depression and simple phobia through an interpreter in the North East of England. *The Cognitive Behaviour Therapist, 5,* 102-111. http://dx.doi.org/10.1017/S17544	35 year old female (moved to England from Middle East)	Case study involving CBT with patient through an interpreter experiencing simple phobia and depression	Patient's symptoms improved through treatment. Therapeutic relationship – therapist humble, open to learning Learning and supervision – third

APA Citation	Participants	Study Information	Central Findings
70X13000044			person a comfort, close supervision
			Interventions – behavioral interventions useful due to reliance on basic human learning rather than language
			In-session dynamic – therapist unable to interrupt, agenda change
Penn, C., & Watermeyer, J. (2012). When asides become central: Small talk and big talk in interpreted health interactions. *Patient Education and Counseling, 88,* 391-398. http://dx.doi.org/10.1016/j.pec.2012.06.016	17 asides with untrained interpreters, 3 different settings – pharmacy, HIV pediatric clinic, child psychiatry clinic.	Qualitative study analyzing asides between interpreters and patients in South Africa	Identified big talk and small talk. Small talk is socially oriented and aligns interpreter and client. Big talk is related to services and care.

Patient-initiated asides give insight into real agenda, concerns, and needs that may have not emerged.

Strengthened notion that information verbatim is unrealistic, myth that interpreter can remain neutral. In successful triad there seems to be fluidity of role and trust b/n interpreter and client. |
| Price, J. (1975). Foreign language interpreters in psychiatric practice. *Australian and New Zealand Journal of Psychiatry, 9,* 263-267. doi:10.3109/00048677509159860 | 3 psychiatrists

3 interpreters.

Each doctor worked with each interpreter in turn to make up 9 different interview pairs. | Quantitative study investigating the frequency and types of error in interpreting during psychiatric interviews and what criteria could be established to identify good interpreters | Contrary to what the researchers hypothesized, the least experienced interpreter was most accurate (higher English proficiency).

Most common type of error was leading questions and distortion of questions, omission of part or whole answer from patient.

Increasing patient disturbance led to more errors in relaying patient answers |
| Pugh, M. A., & Vetere, A. (2009). Lost in translation: An interpretative phenomenological analysis of mental health professionals' experiences of empathy in clinical work with an interpreter. *Psychology and Psychotherapy: Theory, Research and Practice, 82,* 305-321. doi:10.1348/147608308X397059 | 10 therapists (psychology, occupational therapy, mental health nursing) | Qualitative study exploring 4 key interests: experience of empathizing with clients using interpreters, potential changes or differences in empathy, challenges or obstacles to empathy, empathic benefits of using interpreter | Themes:
1. effects of translation upon quality of empathic dialogues with client
2. changes in empathic communication and the difficulty of evaluating client's reception of professional's empathy
3. effects of shared cultures and cultural differences within client-interpreter, client-professional dyads upon empathy
4. opportunities for interpreters to |

APA Citation	Participants	Study Information	Central Findings
			enrich professional's understanding of client
Raval, H. (1996). A systemic perspective on working with interpreters. *Clinical Child Psychology and Psychiatry, 1,* 29-43. doi: 10.1177/1359104596011 004	12 therapists 1 interpreter	Quantitative study on the effect of interpreters on the therapy process.	Themes: Enhancement or limitation to work, content of session and issues raised, effects on the roles of the therapist and the interpreter, effects on the therapeutic style, discussion of cultural differences. Interpreter perspective: helped family understand therapist, family more comfortable with topics, perceived therapist as experiencing loss of authority, greater flexibility enhanced her work, role limitation limited her work

Raval, H., & Smith, J. A. (2003). Therapists' experiences of working with language interpreters. International Journal of Mental Health, 32, 6-31. Retrieved from http://www. scimagojr.com/journalsearch.php? q=14892&tip=sid	9 child and adolescent mental health practitioners	Qualitative study exploring child and adolescent mental health practitioners' experiences working with foreign language Interpreters in the UK.	Themes:
			1. Process of communication through translation
			  a. Communication and language
			  b. The translation process
			2. Impact on therapeutic style
			  a. Changes in styles of questioning
			  b. Interventions became simplified
			3. Difficulty of establishing co-worker alliance
			  a. working alliance different to therapist-therapist
			  b. power differentials
			  c. Role ambiguity
			  d. Trust
			  e. Difficulty in establishing long-term alliances with clients

Schweitzer, R., Rosbrook, B., & Kaiplinger, I. (2013). Lost in translation, found in translation: A case study of working psychodynamically in an interpreter-assisted setting. *Psychodynamic Practice: Individuals, Groups and Organisations, 19,* 168-183. doi: 10.1080/14753634.2013.778487	52 year old Cantonese man with depression Female Chinese born interpreter	Case study involving short-term 12 session psychodynamically -oriented intervention working with an interpreter.	Level of intimacy can be achieved in interpreter setting sufficient for the id of transference and countertransference Key role of supervision. Interpreter contributes to unconscious dynamics – interest, attention, and empathy appreciated by client. Beginning therapist felt "left out" over time began to see interpreter as vital.

APA Citation	Participants	Study Information	Central Findings
			Interpreter changed by process as well – family member with mental illness
Yakushko, O. (2010). Clinical work with limited English proficiency clients: A phenomenological exploration. *Professional Psychology: Research and Practice, 41,* 449-455. http://dx.doi.org/10.1037/a0020996	8 therapists	Qualitative study exploring meaning of lived experiences of therapists providing care to LEP individuals through interpreters.	2 overarching themes: personality and training of both interpreter and therapist.

Therapists' and Interpreters' Perceptions of the Relationships when Working with Refugee

Clients

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Abstract

Many refugees that enter psychotherapy need the assistance of a foreign language interpreter.

Training for interpreters in mental health is minimal or non-existent; what training there is

focuses on medical and legal interpretation and minimizes the relationship that exists between

the interpreter and client. Additionally, there is minimal training in marriage and family therapy

programs on using interpreters in therapy. Previous research centralized the therapist and

obscured the reciprocal relationship among interpreter, therapist, and client. The current study

explores the interpreters' and therapists' perceptions of the triadic and dyadic relationships

within the therapist-interpreter-client system. This is the first study to use a systemic lens to

directly examine the question of how interpreters and therapists working with refugee clients

experience the relationships among interpreters, therapists, and refugee clients in therapy. Using

a phenomenological approach, three interpreters and three therapists were interviewed. Four

themes and nine subthemes emerged, and all centered around the triadic relationship between the

therapist, interpreter and client. The dyadic relationship between the interpreter and client

emerged as a predominant theme refuting the idea that interpreters are mere vessels of

communication. This study illuminates the understanding of how interpreters and therapists

perceive the triadic relationship in therapy. It also reveals a circular influencing process within

the triadic system in which the members of the system and the relationships among them

influence their feelings of effectiveness in therapy.

Therapists' and Interpreters' Perceptions of the Relationships when Working with Refugee Clients.

During the fiscal year of 2013, the United States government admitted 69,926 refugees into the country (United States, 2014). Over 45% of the refugees that resettled in this New England state resettled in the town where this study was conducted. Many of these refugees suffered traumas in their home countries and fled dangerous conditions. During and after the resettlement process refugees experience additional stress associated with loss and change (Kirmayer et al., 2011). Recent developers of a refugee health screener found 30.7% of the 251 refugees in their study screened positive for either anxiety, depression, or PTSD (Hollifield et al., 2013). Many refugees do not speak English on arrival to the United States (U.S.), which is one of many barriers to accessing mental health resources (Kirmayer et al., 2011). Once refugees enter psychotherapy, many of them need the assistance of a foreign language interpreter due to this language barrier. The interpreter not only acts as a language broker, but as a cultural broker and advocate for the client. Because many refugees from African countries are not familiar with the traditional Westernized idea of therapy, they tend to rely heavily on the interpreter as not only an interpreter of language, but as a source of support (Raval, 1996).

In many states in the U.S., the training for interpreters in mental health is minimal or non-existent. What training there is focuses on medical and legal interpretation. Many mental health professionals have advocated for increased training in mental health interpretation for both interpreters and therapists (Searight & Searight, 2009; Tribe & Morrisey, 2004; Tribe & Thompson, 2011) and emphasized the unique demands of mental health interpretation. Because of the focus on medical interpretation, many interpreters are trained to work as vehicles for language interpretation only. Many therapists have moved away from this black box interpreting

model to a push for more collaborative working relationships between therapists and interpreters (Dubus, 2009; Raval, 2005). The lack of training that both interpreters and therapists receive on this working relationship results in confusion about their roles and relationships in therapy.

Tribe and Thompson (2011) assert that working with an interpreter is a skill that should be required for all therapists, yet there is minimal, if any, training in Marriage and Family Therapy (MFT) programs on using interpreters in therapy. Marriage and Family Therapists (MFTs) working with refugee clients in collaboration with interpreters may feel confused about the roles of all parties involved. As MFTs working in the context of systems and relationships, it may feel unnatural (and unnerving) to work with interpreters as mere vehicles and not as whole persons. MFTs' knowledge of systems concepts puts them at a unique advantage to manage and facilitate the relationships among therapists, interpreters, and clients. This is important because the quality of the relationship between the interpreter and therapist influences the co-worker alliance (Raval, 2005).

One concept that applies directly to the systemic context of working with interpreters is that of isomorphism. Liddle and Saba (1983) introduced the concept of isomorphism to family therapy as a framework for training and supervision. The concept of isomorphism is the systemic counterpart to parallel processing in individual psychotherapy. It is used to describe similar patterns that appear across various systems. In MFT training, the similarities between therapy and supervision are seen in both the structure and process. The alliance between supervisor and therapist influences the therapeutic alliance between the therapist and client (White & Russell, 1997). In order to create trust and safety between the therapist and client, there needs to be trust and safety built between the supervisor and therapist. By applying the concept of isomorphism to the use of foreign language interpreters in therapy with refugee

clients, it can be hypothesized that there needs to be a trusting and collaborative relationship between the therapist and interpreter to harness a safe and collaborative relationship among all members of the therapeutic system.

Another unique aspect of MFTs is their emphasis on viewing individuals in terms of relationships and as part of larger systems. Marriage and family therapists view human interactions as parts of a system in which a "change in one part will cause a change in all of them and in the total system" (Watzlawick, Beavin Bavelas, & Jackson, 1967, p. 123). This system is composed of the people within the system and the relationships among them. MFTs focus on the relationships that develop among persons within a system rather than on the content. Additionally, MFTs reject the notion of a linear cause and effect pattern in the relationships in the system and rather view it as a circular process. Rather than viewing person *a* causing changes in person *b*, they would see these interactions as circular with no beginning and no end, but rather a constant feedback process (Watzlawick et al., 1967). The system contains multiple relationships influencing change in other relationships within the system in an ongoing feedback loop.

In the instance of therapists working together with interpreters to provide therapy to refugees, the triadic relationship among the therapist, interpreter, and client is viewed as the whole system. Each dyadic relationship of therapist-client, interpreter-therapist, and interpreter-client influences one another in that the therapist-interpreter relationship will affect the interpreter-client relationship, which will affect the therapist-client relationship, and so on. These relationships will continue to evolve and influence one another throughout the therapy process. It is then impossible to view the dyadic relationships as independent units, affecting one person in the system. Much of the research thus far has focused on the effect of the interpreter on

the therapist-client relationship, ignoring the triadic system and the mutual influences of each dyadic relationship within the triad.

In this study a phenomenological approach was used to interview both interpreters and therapists about the development of relationships in therapy with refugee clients. Up until now, few researchers have looked at the experiences of interpreters within a systemic framework. The existing research is rooted in psychiatry and individual psychotherapy, which often consists of a more linear hierarchical structure. The current research fails to focus on the relationships as well as the context of the therapist-interpreter-client triad. The focus has been on the interpreter's impact on the therapeutic process rather than the triadic relationship of therapist, interpreter, and client. At the time of this study, two researchers in another MFT program in the U.S. published a study that examined how elements of power and privilege impact relational dynamics between interpreters and clinicians (Becher & Wieling, 2014). They highlight the importance of the triadic relationship among therapists, interpreters, and clients, and the acknowledgment of power and privilege embedded in these relationships. Becher and Wieling's (2014) focus was on the interpreter and therapist relationship. In this current research study, the therapist is decentralized and the triadic relationship is further explored within a systemic context.

Literature Review

Effectiveness Studies on Therapy with Foreign Language Interpreters

The focus of the research within the fields of psychology and psychiatry has been on the effectiveness of therapy with refugee clients using an interpreter (Brune, Eiroá-Orosa, Fischer-Ortman, Delijaj, & Haasen, 2011; d'Ardenne, Ruaro, Cestari, Fakhoury, & Priebe, 2007; Kline, Acosta, Austin, & Johnson, 1980). The earliest study by Price (1975) examined the problems associated with the use of interpreters in psychiatric practice. He found that important

information was at times omitted from the conversations resulting in the misdiagnosing of patients. Although Price (1975) uncovered important features of interpreting in this setting, he focused exclusively on the individual contributions of psychiatrist and interpreter. The relationships of psychiatrist-interpreter, interpreter-patient, and psychiatrist-patient may have been important variables in the study. Strengthening the relationship between psychiatrist and interpreter may have led to improvement in the communication.

The second study on effectiveness aimed to evaluate therapy and communication effectiveness when interpreters were present (Kline et al., 1980). The study involved 21 Spanish speaking patients who used an interpreter during the initial interview, 40 Spanish bilingual patients who did not use an interpreter, and 16 second year resident psychiatrists. Kline et al. (1980) found that patients who were interviewed with interpreters present were generally more satisfied with the process than the other treatment group. Additionally, the patients who did not use interpreters were generally less pleased with the interview process. The residents' responses were quite different than the patients' in that they thought the patients who were interviewed in English felt more appreciated, more eager to return, and felt better understood than those interviewed with an interpreter. This study suggests that a strong relationship between client an interpreter may have a positive effect on therapeutic outcome.

A more recent quantitative study done by d'Ardenne et al. (2007) yielded similar results to the study done by Kline et al. (1980). D'Ardenne et al. (2007) compared patient outcomes using refugee patients requiring interpreters, refugee patients not requiring interpreters, and non-refugee patients. All three groups were experiencing symptoms of post-traumatic stress disorder (PTSD) and all three groups were treated using cognitive-behavioral therapy (CBT). They found that all three groups improved and the group of refugees who used interpreters had

proportionally more improvement than the refugees who did not use interpreters. The results of both d'Ardenne et al. (2007) and Kline et al. (1980) further emphasize the need to consider interpreters as having integral roles in the therapy system.

A more recent study explored the effectiveness of using interpreters in therapy using a sample size of 190 patients, of whom 48.9% were treated with the use of an interpreter (Brune et al., 2011). The researchers found that there were no significant differences in the Hamilton Rating Scale for Depression scores between groups of patients who used interpreters and the groups of patients who did not, even though the patients who used interpreters tended to experience more difficult psychosocial circumstances.

Three of the four empirical studies on the effectiveness of treatment when interpreters are present demonstrate the benefits of having interpreters involved in therapy. Although Brune et al. (2011) did not find significant differences in improvement between the participant groups, the refugee group did experience more significant psychosocial stressors outside therapy. When clients are asked about their experiences, they clearly align strongly with interpreters, as demonstrated by Kline et al. (1980).

Relationship between Therapist and Client

The majority of research on using foreign language interpreters in therapy focuses on the effects that the interpreter has on therapy (Engstrom, Roth, & Hollis, 2010; Miller, Martell, Pazdirek, Caruth, & Lopez, 2005; Mirdal, Ryding, & Essendrop Sondej, 2011; Penn & Watermeyer, 2012; Raval, 1996; Raval & Smith, 2003; Yakushko, 2010) rather than the therapist-interpreter-client relationship. There has been one research study exclusively focused on the therapeutic alliance among therapists, interpreters, and clients in therapy. Boss-Prieto, de Roten, Elghezouani, Madera, and Despland (2010) looked at the differences in alliance between

each dyadic relationship of client-therapist, client-interpreter, and therapist-interpreter. They found that the clients' ratings of alliance were always closer to the interpreters' ratings than to the therapists' ratings. Boss-Prieto et al. (2010) view the interpreter as an important mediator in the therapeutic alliance between the therapist and interpreter. Although they acknowledge the importance of collaborating with an interpreter to enhance the triadic relationship among interpreters, therapists, and clients, their research focuses on the interpreter's impact on the therapeutic alliance between the therapist and client. This coincides with the more individually focused research studies where the interpreter is viewed as an outsider to the therapeutic process. A more systemic focus on the alliance may be more appropriate for the system to benefit as a whole.

The majority of the research studies have been done through the lens of individual therapy and psychology where transference and counter transference are central to the therapeutic process. When an interpreter is introduced to the therapeutic system, the therapeutic alliance shifts from dyadic to triadic resulting in a highly complex relational dynamic (Schweitzer, Rosbrook, & Kaiplinger, 2013). In the field of MFT, the therapeutic alliance is often complex as multiple members of a system may be present in the therapy room. The alliance is viewed as an interactional and systemic process and not merely a quality that the therapist brings to the client (Sprenkle, Davis, & Lebow, 2009).

Therapist feeling excluded. The literature contains mixed results on therapists' experiences working with interpreters. Many therapists have positive feelings towards the interpreters and consider them as integral components of the work (Miller et al., 2005; Raval, 2005; Raval & Smith, 2003; Schweitzer et al., 2013; Yakushko, 2010). In Raval and Smith's (2003) study, the therapist participants working with interpreters viewed the work positively

when the interpreters were seen as co-therapists working as a team (Raval & Smith, 2003). Raval and Smith (2003) acknowledge that most of the therapists want this co-worker alliance to be stronger and understand that the interaction between the therapist and interpreter is crucial to the outcome of therapy. Although therapists feel this pull to collaborate more effectively with interpreters, many of them feel excluded in these interactions as they notice the bond between the interpreter and client growing stronger (Raval, 2005). This initial feeling of exclusion is related to fears about clients forming stronger therapeutic alliances with interpreters and, therefore, affecting the course of therapy (Hsieh & Hong, 2010; Pugh & Vetere, 2009). Adopting a more systemic focus may help therapists decentralize their position in the triadic relationship and lessen their anxiety about the interpreter and client relationship. This lens is missing from this research and is addressed in the current study.

Relationship between Interpreter and Client

The therapists' fears of detaching from clients when interpreters are present point to the unavoidable bond that emerges between interpreters and clients in therapy. This relationship has not been focused on as an area of study in the literature, but has emerged in the results of multiple studies on therapists' and interpreters' experiences in therapy. In the earlier effectiveness studies, it was clear that patients were more satisfied with treatment with an interpreter present (d'Ardenne et al., 2007; Kline et al., 1980). Later studies using qualitative methods revealed some of the nature of these bonds. Many participants in these studies recognized the initial bond that interpreters and clients share (Miller et al., 2005; Pugh & Vetere, 2009; Raval, 1996; Raval & Smith, 2003). The therapists in these studies noticed that when clients had strong relationships and felt more comfortable with the interpreters, they were able to share more information with the therapists (Engstrom et al., 2010; Hsieh & Hong, 2010; Raval,

2005; Raval & Smith, 2003). At the same time, there is a worry about this relationship in small communities. In these instances, clients' perception of their confidentiality may be affected as they worry about information getting out into the community (Pugh & Vetere, 2009).

Triadic Relationship among Therapist, Interpreter, and Client

The triadic relationship among therapists, interpreters, and clients has been largely neglected in the literature. Much of the research focuses on how the therapeutic alliance between the therapist and interpreter is affected when an interpreter is present. Thompson and Morrisey (2004) write about the move from a dyadic relationship to a triadic relationship in therapy and the advantages and challenges associated with this work. Current research recognizes the need for a collaborative triadic relationship between therapist, interpreter, and client (Engstrom et al., 2010; Miller et al., 2005; Mirdal et al., 2011; Schweitzer et al., 2013). This led researchers to acknowledge the importance of this relationship, but the mental health field has not yet developed guidelines on effective ways to work with and nurture this triadic relationship in therapy.

The therapists, interpreters, and clients in the study done by Mirdal et al. (2011) heavily stress the triadic relationship as the most important curative factor in therapy. Mirdal et al. (2011) explored the curative and hindering factors present when working with refugees and interpreters in therapy. The researchers selected four experienced psychologists and asked them to identify their two most successful refugee cases and their two least successful refugee cases. The researchers then interviewed the psychologists, interpreters, and clients involved in the sixteen therapy cases. Through interviewing the participants, they found one of the curative factors to be the triadic relationship among the client, therapist, and interpreter. All three parties involved in the study highlighted this relationship as one of the most important pieces in therapy.

Engstrom et al. (2010) recognize the presence of the interpreter as contributing to this three-way encounter and identifies the provider-patient, interpreter-patient, and interpreter-provider relationship. This is evidence for the importance of a triadic system and the individuals within the system respecting and enhancing the relationships among them. The current study explores the interpreters' and therapists' perceptions of the triadic and dyadic relationships within the therapist-interpreter-client system. This is the first study to use a systemic lens to directly examine the question of how interpreters and therapists working with refugee clients experience the relationships among interpreters, therapists, and refugee clients in therapy.

Method

A phenomenological approach was used for this study. Phenomenology falls under the umbrella of qualitative research, which has its roots in the fields of sociology and anthropology (Moon, Dillon, & Sprenkle, 1990). Qualitative research is aimed at constructing data in a more inductive manner (Creswell, 2007). Its focus is on subjective responses and more in-depth descriptions from participants involved in the study (Creswell, 2007). Qualitative research fits well within the MFT paradigm because of its roots in similar foundations. Gregory Bateson, who founded cybernetics systems theory, discovered this theory through his ethnographic research in New Guinea (Moon et al., 1990). As Moon et al. (1990) point out, qualitative research may be a good fit for family therapists because "like systems theory, qualitative research emphasizes social context, multiple perspectives, complexity, individual differences, circular causality, recursion, and holism" (p. 364).

A phenomenological study focuses on the shared lived experiences of a group of individuals (Creswell, 2007). Researchers using this approach aim to "reduce individual experiences with a phenomenon to a description of the universal essence" (p. 58).

Phenomenology involves setting aside prejudgments and presuppositions and approaching a phenomenon with an open mind (Moustakas, 1994). Phenomenology as a scientific inquiry was founded by Edmund Husserl who was concerned with the "meanings and essence of knowledge" (Moustakas, 1994, p. 27). Husserl understood the interconnection of the act of consciousness and the object of consciousness. He used the term *epoche;* a Greek word meaning to refrain from judgment, to set aside our preconceived notions of the phenomenon being studied and enter the inquiry with a fresh perspective (Moustakas, 1994).

There are many different approaches to phenomenological research, one of which is interpretive phenomenological analysis (IPA). This study uses IPA because of its emphasis on the participants' personal perceptions of the experience rather than an objective view of it (Smith & Osborn, 2003). This study focuses on the interpreters' and therapists' perceptions of the relationships in the therapeutic system. IPA makes room for both the participant's and researcher's voice in the research, acknowledging that it is not possible for the researcher to attain a completely neutral stance, but it is also important for the researcher's voice not to overshadow the voices of the participants. It also acknowledges that the themes are influenced by both the participant's and the researcher's perception of the experience. The meaning that both interpreters and therapists attribute to the therapeutic relationships was the focus of the study. The overarching research question for this study is:

How do interpreters and therapists working with refugee clients experience the relationships among interpreters, therapists, and refugee clients in therapy?

Participants

In a phenomenological study, it is important to utilize participants who have all experienced the phenomenon being studied. The more common the participants are to one

another, the easier it will be to identify shared meanings (Creswell, 2007). Small sample sizes are best when conducting an IPA study because of the detailed case-by-case analyses and the goal of achieving in-depth perceptions and understandings rather than general ideas (Smith & Osborn, 2003). This study included a sample size of three interpreters and three therapists. Purposive sampling was used to identify participants with shared characteristics. The recruitment of participants was attempted through contacts with two local interpreting agencies. An email was sent to the contacts with a letter of invitation to be forwarded to potential participants (Appendix A). The following criteria were used for inclusion in the study:

1. Foreign language interpreters who have been working in that position for a minimum of one year.

2. Foreign language interpreters who have interpreted in at least five mental health visits.

Letters were also given to foreign language interpreters in person at a local outpatient health center where they regularly interpreted for refugee patients. The participants in this study were those who received personal in-person letters of invitation by the researcher at the outpatient center.

The therapists interviewed were identified primarily through convenience sampling, as they were professionals already known to the researcher or identified through shared sources. The following inclusion criteria were used for this portion of the study:

1. Mental health professionals who have been providing therapy to immigrant and refugee individuals and/or families for a minimum of one year.

2. Mental health professionals who have worked with foreign language interpreters while providing care to immigrant or refugee clients for a minimum of five sessions.

Data Collection

Both the interpreters and the therapists completed a demographics questionnaire (Appendices B and C). They completed this questionnaire in the interview setting before engaging in the interview. They were asked to fill it out themselves to avoid the closed answer questions influencing the interview process. After the questionnaire was completed, the participants engaged in open ended, semi-structured interviews (Appendices D and E). The interviews were conducted face-to-face in settings comfortable to the participants. The therapist participants chose to be interviewed at their place of work. The interpreter participants chose to be interviewed at the outpatient center from which they were recruited. The three broad questions in the interpreter interview were:

1. What have you experienced in your relationship with the counselor in mental health sessions?

   a. How do you think the client experienced those relationships?

2. What were the elements of the relationship that were really useful?

3. What were the elements of the relationship that were challenging?

The three broad questions in the therapist interview were:

1. What have you experienced in your relationship with the foreign language interpreter in mental health sessions?

   a. How do you think the clients experienced those relationships?

2. What were the elements of the relationship that were really useful?

3. What were the elements of the relationship that were challenging?

The interviews were semi-structured and guided by the research question's focus on the interpreters' and therapists' perceptions of the relationships formed among interpreter, therapist

and refugee client. The interview questions were general and open with the intent of getting information most pertinent to the participants. General follow-up questions were used only if the information provided by the participant did not fully capture their experiences. Brief notes were taken during the interview process. This was to help track the responses of the participants and to gain deeper understandings of the participants' meanings. The interviews lasted from thirty minutes to an hour and were audiotaped. They were then transcribed verbatim by the researcher using Express Scribe transcription software.

Data Analysis

The data were analyzed using IPA as described by Smith and Osborne (2003). Meaning is central to IPA and to fully understand the meanings of the participants' experiences, the researcher needs to engage with the text in the process of interpretation (Smith & Osborne, 2003). This was done by reading the transcripts multiple times and making notes on any observations and reflections. After these observations were recorded, the transcript was re-read for emerging themes. The initial notes taken were used to transform the phrases and capture the essential meanings of the units of text. This transformation of units into themes was continued through the whole transcript. As similar themes emerged, theme titles were repeated. The emergent themes were organized into clusters based on their connections. After creating clusters of themes, a master list was created (Table 1) to keep track of the subthemes and the units of meaning. This process was repeated for each transcript and additional clusters were developed to make room for new themes that emerged. Once all the transcripts were analyzed, the themes were re-examined and organized into main themes and subthemes.

Ethics

This study received approval from the Institutional Review Board at both Antioch

University New England and the healthcare institution in which the researcher worked

(Appendix F). The informed consent form (Appendix G) was given to the participants prior to

the interview. This was gone over extensively with the participants before engaging in the

research. Confidentiality was ensured by assigning each participant a number code that was used

to refer to transcripts. The transcripts and any identifiable information were stored in a password

protected file on the researcher's personal laptop.

Bias Statement

According to Moustakas (1994) researchers should write about their own experiences

with the research to make transparent the context that may influence their experiences. This

assists in the process of setting aside biases or bracketing while conducting the

phenomenological inquiry. It is acknowledged that the researcher's experience influenced the

perception and identification of meanings and it is important to make those perceptions

transparent. Prior to this study, a bias statement was written to bracket the researcher's

experience and to highlight the voices of the participants involved. A more detailed description

of this bias can be found in Appendix H.

The initial bias statement included the researcher's experience as an immigrant and a

therapist working with foreign language interpreters. The researcher was born in South Africa

and moved to the U.S. at age 17. This experience was different to the refugees' experiences as

immigrants often have more choices in their resettlement. The process of feeling like an outsider

is a shared experience between immigrants and refugees and one that influenced the researcher's

interest in this subject. The marginalization of refugees in the U.S. and the lack of attention that

is paid to their needs led the researcher to pursue research that contributes to more effective care

for this population. The researcher was similar to the interpreters in this study as they were all foreign born as well. This may have allowed the interpreter participants to say things they may not have said to a researcher born in the U.S. This came up in the interpreter interview when an interpreter described how she finds it more helpful to work with therapists who have travelled globally and have a deeper understanding of culture.

The researcher's experience working with foreign language interpreters as a therapist influenced her lens as well. As a therapist, she experienced mostly positive working relationships with interpreters and noticed strong interpreter-client relationships. Because of this bias, she needed to be aware of how she was viewing themes in the data. Throughout the analysis process, she remained aware of the uniqueness of each participant and the importance of allowing their meanings of the experiences emerge. To add an additional layer of trustworthiness, a triangulated investigator was used during this analysis phase. This triangulated investigator analyzed the transcripts independently for themes and compared these themes with the principal investigator's identified themes.

<div align="center">**Results**</div>

Demographics

The participants in this study consisted of three mental health professionals and three foreign language interpreters. Due to the small number of participants and small state in which the research was conducted, the demographic information will not be further delineated to protect participant confidentiality.

All three mental health professionals have been practicing therapy for over 15 years. They have each worked with foreign language interpreters in over forty sessions, two of whom have worked with them for over one hundred sessions. All three clinicians indicated that they

had not received any formal training on working with interpreters and gained their knowledge of the work through practical experience, and trial and error.

The three foreign language interpreters who participated in this study were all born in Eastern African countries. They have all interpreted in over 50 mental health sessions, and two of them have interpreted in over 100 sessions. The number of years working ranged from one to eight years. Two participants received one day trainings on interpreting in mental health sessions and one gained her knowledge in this area through her own experience in the field. The participants were proficient in the interpretation of Swahili, Kinyarwandan, Kirundi, and French.

Themes

Four major themes and nine subthemes emerged from the interviews. The first and central theme that emerged was the *triadic relationship among the therapist, interpreter, and client.* This theme emerged as the foundation for three additional themes, *the relationship between the interpreter and client, the relationship between the therapist and interpreter,* and *the relationship between the therapist and client.* The interconnectedness of these themes is conceptualized as a Venn diagram (Figure 1), which illustrates the overlapping phenomena of these themes in the center as the triadic relationship as well as the unique aspects of each relational dimension.

Triadic relationship among therapist, interpreter, and client. The central theme of the triadic relationship describes the role of the interpreter as an integral part of the sessions. This main theme includes the subthemes of *interpreter part of therapeutic system*, and *three-way comradery*.

Interpreter part of therapeutic system. The therapist participants saw the interpreter as becoming part of the therapeutic system over time and part of the therapeutic relationship. This can be seen in this quote by one of the participants:

> …not just as only a voice, but as somebody who is a part of the relationship that the three of us have.

The therapists saw this inclusion as a contributor to the effectiveness of therapy. Two of the therapists thought it best to have the interpreter part of this relationship to increase the quality of therapy for the client. One of the interpreter participants described the importance for her to know some of the background and context of the therapy session to increase her effectiveness. This interpreter shared that it is helpful for her when the therapist, interpreter, and client all understand one another and have an idea about what is emerging in therapy. She also described how difficult it is for her when she interprets for new clients with no prior information about the session. This is illustrated in the following quote:

> I think because there are times where I have to cover up for an interpreter who works for the same patient and then you show up and you're like, what is that all? So you have all the questions and you're trying to understand what's going on, but it's really hard so you're not familiar with anything because I think once, um, when the three have, um, seen each other frequently.

Three-way comradery. Within this triadic relationship lies a three-way comradery that is felt by the therapist, interpreter, and client. This three-way comradery is thought of as an inclusive process where the therapist, interpreter, and client occasionally share ideas and thoughts among the three of them and join as a triadic unit. As one therapist described it,

There's just a feeling like of [laughs] comradery sort of in the, you know, that we're all in
this together. You know? Even though the interpreter is interpreting, I get that the
interpreter gets it. We can all kind of laugh or cry or whatever with one another.

This process of going back and forth among the three of them eases the therapeutic
process as the three members feel in sync with one another in session.

In order for this three-way comradery to occur, a relationship needs to be built among the
therapist, interpreter, and client. This relationship builds over time and is influenced by multiple
factors identified by the participants. One therapist recognized the importance of building this
relationship in the following quote:

And so if you have, kind of, three people who are all kind of getting to know each other
and each other's style then everybody, you know, did a little bit better, um, or got more
effective.

This relationship builds as the number of therapy sessions increase and is at times
accelerated by the influence of the interpreter. The interpreter plays a role in the facilitation of
this triadic relationship building over time. The interpreter participants in this study identified
some ways in which they facilitate the connection between the therapist and client while
remaining engaged in session. One of the interpreters recognizes her role as both the client and
the therapist's voice. Another described his strategy of speaking in first person and redirecting
questions to the therapist as a way to facilitate this connection.

Interpreter and client relationship. The relationship between the interpreter and client
emerged as a large theme in the study. The subthemes included in this theme are *interpreter and*
client connection, client trusting interpreter, and *interpreter knowing client in small community.*

Interpreter and client connection. The therapist participants acknowledged this relationship as an important part of therapy and helpful for the clients to feel comfortable in sharing information. One therapist illustrates this point by saying,

> They started making that connection, they start noticing some benefit, um, and if they can have, you know, if they're comfortable with the interpreter, then you can, you know, then it just, everything is more effective for everybody. You can see that they're, you know, more comfortable.

This comfort between the interpreter and client is noticed by the therapist who can see a difference when the client feels comfortable with the interpreter. One therapist participant acknowledged this and said,

> When they have a different interpreter they seem to behave differently.

The client begins to request the same interpreter for each therapy session; one participant described the reluctance of clients to attend sessions if the regular interpreter is not available. Both therapist and interpreter participants described the client's comfort in sharing more when the relationship between the interpreter and client is present. Additionally, the participants talked about the client feeling supported by the interpreter. The clients may even look to the interpreter initially for help because they feel a connection with them before feeling connected to the therapist. This connection is based on shared experiences of the interpreter and client. Although this connection exists, the interpreter continues to maintain professional boundaries with the client.

Client trusting interpreter. The connection that is built between the interpreter and client relies heavily on trust and the development of trust within the context of their relationship. One interpreter highlighted the importance of clients needing to trust interpreters by stating,

Trust is the number one thing. If a patient doesn't trust you, you will make your

interpreting very difficult. They have to trust you. That's the number one thing.

Two of the interpreter participants shared ideas on how they believe the trust is developed

in the relationship. One of the ways is building upon the shared culture of the interpreter and

client. One interpreter said the following:

One thing I've realized with the clients, be an African. Don't show up and you talk

about, um, because you know we're taught to not have, like don't talk to them in the

lobby, don't engage in, um, conversations that are not necessary, but in the African

culture that's how somebody trusts you. With, "Hi. How are you? How is your family?

How is everything going?" That's how they trust you.

The interpreters also acknowledged the role that a genuine and collaborative stance of the

interpreter can play in trust building as well as the accuracy of interpretation. When interpreters

take a more collaborative stance, clients respond positively and feel more comfortable in the

therapy sessions. One interpreter discussed the importance of not "lording over them." This is

illustrated in the following quote:

To try put myself on the same level as the client. That way he feels or she feels

comfortable, you know, she feels that I am not over anybody. I'm not over him or her.

I'm not over doctor or the provider.

The interpreter acknowledges that this collaborative stance is his way of connecting with

the client and is based on cultural understandings of connection of both interpreters and clients.

This is a significant factor in building these relationships, as one interpreter referenced a past

case in which a client no longer wanted an interpreter to interpret for their sessions because they

were seen as unfriendly and judgmental. She acknowledged the role that hierarchy played in this situation and the client discomfort with the superiority conveyed by the interpreter.

As the interpreter and client build on their connection, the therapist involved may question this relationship and feel unable to assess the client comfort level directly in therapy. One therapist described her discomfort in not knowing the client's comfort level and her limitation in not being able to ask the client without the interpreter present. This participant described her discomfort not knowing the influence of the interpreter on client responses in the following quote:

> There's always this feeling that, am I getting the information that I really need or that the client really wants to say? Let's put it this way, not that I need, what the client wants to, um, provide or need to say or does it truly reflect where they are? How much influence is the presence of this person?

Interpreter knowing client in a small community. The other subtheme that emerged within this main theme was *interpreter knowing client in small community.* Two of the therapist participants worry about confidentiality in a small community and acknowledge the dilemmas that interpreters face in these scenarios. This can be seen by one of the therapists saying,

> You know, more for the client's sake that even though…that I'm sure the interpreters sign a confidentiality statement. I mean obviously they have to, but I do…but still the client knows they know, they know, they know. They have husbands. Do they go home and say anything to their husband or their sister or their…?

Two of the interpreters in this study talked about their interactions with clients outside therapy sessions and both presented slightly different responses. One interpreter participant feels like an additional counselor to clients and listens to them outside therapy sessions, but is careful

not to offer advice. The other participant was more wary about listening to clients outside

sessions and struggled to maintain professional boundaries. This interpreter found clients to be

demanding of him outside therapy sessions and has to repeat his professional stance to them until

they understand his role in therapy. For example, he says,

> So that also can be a challenge living in a small community because people get to know
>
> you and they can try to call you, even though you don't call them. I mean I don't give
>
> them my number but small communities they know how to get somebody's number so
>
> they can just call me and be like, "what did the doctor say the other day?" and I'm like, "I
>
> don't remember. I just interpreted and forgot. That's my job." So, yeah, that can be
>
> challenging.

This particular interpreter was adamant about clarifying his role as an interpreter prior to

each therapy session in order to maintain his professional code of ethics and protect both himself

and the client from blurring the boundaries between them.

There are times when the interpreter is requested to interpret for clients who he or she

knows personally. Two of the interpreters in this study discussed their awareness about the

implications of interpreting for someone they know. They both said it is more difficult to be

impartial and to remain emotionally stable in these situations. In these instances, the interpreters

said that they would not accept the requests to interpret or stop interpreting in the cases if they

had already begun. One of the interpreters acknowledged the risk involved in possibly

overstepping boundaries in these situations as illustrated below:

> So I may tend to step in, you know, say something, counsel, say "you shouldn't say that."
>
> you know, or "you should say that. You should tell her this," because sometimes
>
> interpreters recognize the problem before counselors do because you know the

background, you know what he went through, we all went through quite the same thing

so, and you coped with it. You were able to overcome it. Why? You may have your own

reasons or your own things that helped you that he or she doesn't have yet, so you may

want to share, so if it's somebody that you know, the probability is you're going to step

in. You're gonna really bad want to step in and say something.

This presents a dilemma for the interpreter who wants to help, but is unsure about his role

in the process.

Therapist and Interpreter Relationship. The third main theme is the *therapist and*

interpreter relationship. This theme includes two subthemes, *therapist and interpreter have a*

personal relationship, and *building the relationship between therapist and interpreter.* This

theme was not as extensive as the interpreter's relationship with the client, but has important

implications for the effectiveness of therapy.

Therapist and interpreter have a personal relationship. All three therapist participants

commented on the personal and professional relationship that they have with the interpreters

with whom they work. They described knowing personal things about the therapist and at times

bringing those things into the therapy session. One described it as,

It's al- it's strictly professional, but there's a personal side that we bring into

the…relationship and the therapy.

This leads to the therapists having a preference for certain interpreters in therapy, similar

to clients requesting the same interpreter for every session. The therapist participants viewed

this personal relationship as beneficial to therapy and one felt as though she was starting over

whenever a new interpreter showed up for sessions. This participant said:

I guess I have to say what really helps is really getting to know the interpreter, familiarity with the interpreter and the interpreter being familiar with you.

Although this personal relationship benefits the therapeutic outcome, there are complexities involved that need to be considered. One therapist brought up this complexity in her awareness of this personal relationship in the therapy room and her hesitancy to get caught up in personal conversations with the interpreter, leaving the client out of the conversation.

You know not get caught up with…let's say I know the interpreter, I don't know, just got married or something like that, you know, not start talking, to avoid talking to the interpreter about his or her personal life, although after the session, you know, when the client is gone or if I happen to see them somewhere, you know, we might have that conversation, just because, you know, we know each other.

Building the relationship between therapist and interpreter. Five of the participants talked about how this relationship builds over time, contributing to the theme of *building the relationship between therapist and interpreter.* One of the therapist participants discussed her trust of the interpreter and how this trust seemed to be present early on in therapy. Another therapist talked about trust building over time and experience. This same therapist acknowledged the human qualities of the interpreter that contribute to feelings early on in therapy,

You have different responses to peers that you're working with. They're people too. They're not robots like the guy who tried to sit behind the uh…you know?

All three therapists discussed comfort building over time with the interpreter as they get to know the interpreter personally. The trustworthiness and comfort that builds over time was dependent on the working relationship between the therapist and interpreter. One therapist

participant identified demonstrations of competency and professionalism by the interpreter as important factors in the building of the relationship. These factors provide insight into the intricacies of developing this working relationship and the importance of both personal and professional characteristics of the interpreter.

  Therapist and client relationship. The fourth theme that emerged from the data was the *therapist and client relationship.* This theme contains two subthemes of *cultural impact on therapist and client relationship,* and *effect of therapist and client relationship on interpreter.*

  Cultural impact on therapist and client relationship. The *cultural impact on therapist and client relationship* was primarily identified by the interpreter participants in this study. For them, culture played a big role in the connection between the client and therapist, and in their role in therapy sessions as illustrated in the following quote:

> The culture, because the culture is…I would repeat again, culture is the main thing, you know, because they have their own culture and you may know how to counsel and that's what you're doing and that's a good thing, but sometimes culturally speaking like an elderly person may be or feel like he cannot be counseled or she cannot be counseled by a person younger than him or her.

One interpreter brought up the aspect of race and how it can affect the therapeutic alliance in the beginning:

> *Participant:* Because one thing I realized with the clients that I work for, it's hard for them to trust, um, I don't want to say white people. *Interviewer:* You can say it.
>
> *Participant:* Yeah. It's hard for them to trust…*Interviewer:* White people. *Participant:* Basically, like, white people. Because they're not used to, um, they're not used to them, you know. They're used to their black people.

When talking about the challenges that emerge in the relationship between the therapist and interpreter, the interpreters brought up the cultural misunderstandings that happen in the therapy sessions between the therapist and client. These cultural misunderstandings were identified by the interpreters in the room and made it difficult for them to facilitate the relationship between the therapist and client. Two of the interpreters talked about these misunderstandings impacting the therapy sessions. One said the following statement while referencing the cultural differences around eye contact:

> So for some counselors [wondering why client isn't looking at them] so she may be like, "why aren't you looking at me?" You know? And the client may be offended a little bit so, "Who do you think you are? You want me to look at you when I'm talking to you? That's disrespectful. So you want me to be disrespectful?" So they can be like, "he's not a good man, she's not a good woman. She wants me to be disrespectful. How is she going to help me?"

These instances often lead to the interpreters interjecting in their roles as cultural brokers. They interject the most when they see therapy being impacted by the cultural misunderstandings. All three interpreters talked about this role and their facilitation in the building of the therapist and client relationship. Many times, they can successfully fulfill this role in therapy, but one interpreter discussed some frustrations related to this role.

> It's very hard to put your point across because you find yourself repeating yourself over and over again and even when you explain, um, the difference, like the cultural difference. I think, um, for somebody who's never been, who's never grown up in that kind of environment it will be hard for them to understand why that is.

For her, it is more helpful when therapists have travelled outside of the U.S. because in her experience those therapists who travelled more seemed to be more understanding of cultural differences. Therapists also identified culture as an integral part in working with refugee clients and one therapist acknowledged its influence on the therapeutic alliance as she questioned the influence of culture on the client's ability to share information with the therapist.

> But, all of those things I didn't know whether maybe that's just you don't talk about it, you know, maybe that's just a cultural thing or maybe she didn't want to talk about it with me or was she embarrassed or, I don't know.

The therapist here is aware of these cultural differences and is struggling to find a way to bridge this gap. Therapists identified ways in which they connect with clients beyond the use of language as a means of communication. Two of the therapists in this study discussed nonverbal communication as a way to transcend the reliance on verbal connection. One therapist described it below:

> Really pay attention, I think, also to body language, um, because, you know, things can get lost in the translation, right? And so since we observe a lot by body language and facial expressions and, you know, don't discount that just because someone is interpreting for you.

Effect of therapist and client relationship on interpreter. The interpreters in this study were not only affected by the cultural issues in the relationship between the therapist and client. They were aware of other aspects of this relationship that influenced their ability to interpret effectively. The level of comfort between the therapist and client affected the interpreter and the interpreter picked up on these in the therapy room. One interpreter said that it was challenging

for her when the therapist and client did not know each other, and helpful when they had some connection.

> When I work with clients who are very familiar and very comfortable with the counselor there tend to be more, um, positive things, you know. They'd be smiling or laughing or make jokes about things, um, so when there is a good relationship between the client and the counselor it makes your job way easier.

This is similar to therapist responses about the interpreter and client relationship. The interpreters identified some ways in which they perceive helpful for therapists in building relationships with clients. One interpreter talked about a collaborative stance and empathic responses as ways in which the therapist builds this relationship with the client.

> When you see the counselor showing empathy and also supporting the family and not just the person, I know, from that moment on, I know things are going to be good. I know this is going in a good place.

This collaborative stance is connected to cultural ways of connecting and the interpreter's collaborative stance with the client, which emerged in the *interpreter and client relationship* theme.

Discussion

Triadic relationship

The central theme of the triadic relationship illustrates the importance of having all three parties working as a team in therapy. This triadic relationship places equal importance on the expertise each member brings to the triad. The therapist participants viewed interpreters as part of the process rather than an outsider affecting the course of therapy, which is different from previous studies examining the effects of interpreters on the therapist-client relationship. It is

more consistent with viewing the triadic system as a whole. The therapists in this study saw this triadic relationship as a contributor to the effectiveness of therapy, which is consistent with Mirdal et al.'s (2011) findings, in which interpreters, therapists, and clients identified the team as the single most important curative factor in therapy.

Within this triadic relationship is a three-way comradery that involves the therapists, interpreters, and clients sharing ideas and joining as a system. This is seen as a collaborative process where all expertise are welcomed into the triad. When interpreters are not seen as equal members of this triad, they are more likely to be viewed as black box interpreters who are present to interpret language only. In these instances they may not be briefed prior to sessions, or assumed that they do not require client context to work effectively. One interpreter in this study discussed the difficulties in interpreting for new clients when she doesn't know the background. She found it more helpful when the therapist, interpreter, and client have seen each other frequently and have developed that triadic relationship. This is important for therapists to know when working with interpreters so that they can brief interpreters before sessions and build on the triadic relationship.

Participants in this study spoke about interpreters playing a role in the building of this triadic relationship. The interpreter's initial bonding with the client based on shared experiences assists them in this role as they act as the conduit between therapist and client. This places therapists in a less powerful position in the triad as they need to rely on interpreters to facilitate this bond. This helps build the collaborative nature of the triad as therapists are able to provide space for the interpreter's expertise. In this study interpreters identified their body language, eye gaze, and redirecting of questions as ways in which interpreters can facilitate the relationship between the therapist and client and strengthen the triad as a whole.

Interpreter and Client Relationship

The relationship between the interpreter and client emerged as a large theme in the study. This is consistent with other studies where this theme emerged consistently even when the focus was not on this relationship (d'Ardenne et al., 2007; Hsieh & Hong, 2010; Kline et al., 1980; Miller et al., 2005; Pugh & Vetere, 2009; Raval, 1996; Raval & Smith, 2003). In other studies therapists felt excluded from this connection in the beginning (Hsieh & Hong, 2010; Pugh & Vetere, 2009; Raval, 2005). This theme did not emerge in the present study, but rather therapist participants saw this bond as a contributor to a more positive therapeutic outcome.

Similar to the literature, the participants in this study stressed the importance of having the same interpreter with the same client for every session (Tribe & Lane, 2009). This is consistent in most of the research in this field and should be respected by therapists working with refugee clients (Engstrom et al., 2010; Hsieh & Hong, 2010; Raval, 2005; Raval & Smith, 2003). The importance of fostering this safe relationship is central to clients feeling comfortable and sharing information. This idea was expressed by both therapists and interpreters in this study.

The challenges of living and seeking mental health treatment in a small community emerged in this study, which is consistent with past literature on this topic (Pugh & Vetere, 2009, Tribe & Thompson, 2011). This study was conducted in a predominantly white, rural New England state. The refugees who resettle here form small communities and the interpreters with whom the work become part of these communities. The interpreters often either know the client personally in the community or know family members and friends of the client. If the interpreter does not know the client personally prior to starting a professional relationship, they are still likely to see them in the community after sessions have begun. This can present challenges for

the interpreter who is trying to maintain professional boundaries and challenges to the client who may worry about confidentiality.

Both the therapists and interpreters were mindful of this and felt challenged by confidentiality and boundaries. This can be a complex relationship to navigate for interpreters. Whereas therapists receive training on managing the relationship between therapist and client, interpreters receive little training on this phenomenon. Currently, interpreters approach this challenge with their own professional code of ethics that applies to medical and legal training. When interpreters are not seen as part of the therapeutic system, this complex relationship may be ignored in their training. It is important to view the interpreter-client relationship as part of the triadic system and, therefore, influencing the therapeutic outcome.

Although it is recommended that interpreters not interpret for anyone they know personally (Björn, 2005), in small communities it is challenging for interpreters not to interpret for clients they know. This is important because the interpreters in this study acknowledged the difficulties they would have remaining neutral in situations where they know the client personally. They acknowledge the risk in wanting to step in based on shared cultural experiences and ways of coping. This shared background allows for the interpreter to know about culturally appropriate interventions before therapists at times and would be tempting for them to interject with this knowledge. Working in collaborative relationships, as described by Raval and Smith (2003), would make more room for these kinds of interactions as the therapists and interpreters would be working together in a co-worker alliance. Having clearer guidelines for interpreters to navigate this complex relationship would be helpful for their work in mental health.

One of the interpreter participants in this study discussed the challenge of wanting to advocate for clients known to him or her. This interpreter was a refugee as well and had shared

experiences that would be helpful for the refugee client and the therapist. This reflects the worry that some therapists have about refugees interpreting for refugee clients. Most of the literature on this topic points to more benefits than risks in these cases. Miller et al. (2005) found that the refugee interpreters in their study experienced some distress after interpreting, but were able to use coping skills to decrease distress level in a short amount of time. The interpreters in this study have the ability to assist the therapists in a significant manner by being able to recognize client distress based on shared cultural experiences. If the working alliance between interpreter and therapist was strengthened, this information could be invaluable to the treatment of the client in therapy.

Therapist and Interpreter Relationship

The therapists in this study described both the personal and professional relationships they have with interpreters. This familiarity built a sense of comfort in the room that contributed to clients feeling comfortable as well. The therapists identified having mostly positive relationships with interpreters, consistent with other therapists' experiences in previous studies (Miller et al., 2005; Raval, 2005; Raval & Smith, 2003; Schweitzer et al., 2013; Yakushko, 2010). This is consistent with the literature, which has shown therapists to feel more positively about their work with interpreters when they view them as co-workers in the process (Raval, 2005; Raval & Smith, 2003). The therapists most likely build relationships with interpreters towards whom they naturally gravitate, having preference for certain interpreters in therapy. This was acknowledged in their description of the human qualities of interpreters impacting their comfort level, refuting the idea that they are conduits of language only.

The therapist participants also acknowledged a level of trust that is needed between the therapist and interpreter. They discussed the building of this trust over time. This is also

reflected in the client and interpreter relationship, where the interpreters in this study spoke about the importance of trust in their relationship with the clients. The trust felt between therapist and interpreter is likely felt between interpreter and client, which affects the therapist-client relationship. If a strong interpreter-client relationship is linked to a positive therapeutic outcome, then this systemic view of trust within the triad is essential to the process.

Therapist and Client Relationship

Cultural misunderstandings emerged as the most prominent subtheme under the main theme of therapist and client relationship. Although many researchers acknowledge the importance of culture in working with interpreters and refugees (Brune et al., 2011), the theme that seems to come up most frequently is the feeling of exclusion therapists face when interpreters and clients share these cultural bonds (Hsieh & Hong, 2010; Pugh & Vetere, 2009; Raval, 2005). In this current study, it was the interpreters who commented more on the impact of cultural misunderstandings on the therapeutic relationship between the therapist and client. The therapist participants recognized these cultural misunderstandings as well, but the interpreters' perceptions of the therapist and client relationship was heavily influenced by the cultural differences between them.

Interpreters were quick to pick up cultural differences and felt frustrated at times when therapists were unable to understand how the culture was affecting therapy. One interpreter's frustration came out of her feeling that the therapist did not understand the differences even after she fulfilled her role as cultural broker. This can be difficult for all parties, especially if the roles and relationships are not clarified in the beginning. When therapists are more open to developing working alliances with interpreters, this information may be more readily shared and therapists may be more open to receiving it and using it in therapy. For this to occur, therapists

need to be more open, flexible, and transparent in therapy to allow for more than one expert in the room. This coincides with the idea of a therapeutic triadic system in which all voices are respected and heard.

The idea that the relationship between the therapist and client affects the interpreter is not represented in the literature. This may be because researchers are often looking at the impact of interpreters on the therapist's ability to work effectively. Research has not examined the impact of therapists on the interpreter's ability to work effectively.

Limitations

It is beyond the scope of this research project to interview refugee clients in therapy. It would, however, be beneficial to gain the client's voice in therapy, which would add to the understanding of the triadic system. The client's perception of the relationships would substantially add to the understanding of the relationships within the triad. Although there have been few studies down with refugee clients, Vara and Patel (2012) point out that most of these studies focus on their trauma, creating a lens through which people view refugees in general. There are no qualitative studies on the client's experience in therapy using a foreign language interpreter. Barriers to this study include the inability to interview clients without the use of an interpreter and the difficulty in participant recruitment, making research in this area considerably more complex. Vara and Patel (2012) and Ingvarsdotter, Johnsdotter, and Östman (2010) provide some guidelines on qualitative research with interpreters. Vara and Patel (2012) suggest gaining trust and participation from a key contact person in the community and paying attention to power within the relationships. They present important challenges they encountered in their own research that provide invaluable information to future work in this area.

In addition to this limitation, the study is limited to a small region of the United States where there is not a lot of training for interpreters in mental health. Results may be different if the study was done in an area where ethical and clinical guidelines for interpreters have already been established.

Conclusion

In this study the interpreters and therapists discussed their perceptions of the triadic and dyadic relationships within the therapist-interpreter-client system. Interpreters viewed stronger relationships with therapists as positively impacting their work. The therapist participants had similar feelings in that they felt more effective in their work with clients when they had good co-worker relationships with interpreters. Both the therapists and the interpreters were affected by the relationships that each had with the clients. The interpreters' perceptions of the therapist-client relationships influenced their work in therapy and the therapists' perceptions of the interpreter-client relationships influenced the therapists' work with their clients. This reflects a circular process within the triadic system in which all members influence one another and their perceptions of the relationships influence their responses and feelings of effectiveness.

This is the first phenomenological study using a systemic lens to directly examine how interpreters and therapists working with refugee clients experience the relationships among interpreters, therapists, and refugee clients in therapy. Although some researchers have examined the impact or role of interpreters in therapy, the relational aspect has been largely ignored. The research on the therapeutic alliance that does exist is rooted in individual psychology and focuses on the therapeutic alliance between therapist and client. Marriage and Family Therapists could play a larger role in this area of work because of their focus on systems and relationships. The refugee client's voice is needed in this research to develop an even fuller

picture of this triadic system. Developing and sustaining a healthy triadic system composed of the therapist, interpreter, and refugee client is essential to the outcome of therapy for refugee clients. It is imperative that researchers look at these relationships in more depth to provide effective treatment to a population who have already suffered so many social injustices.

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THERAPIST AND
INTERPRETER
1. Therapist and interpreter have
a personal relationship
2. Building the relationship
between therapist and
interpreter.

Interpreter

INTERPRETER AND
CLIENT
1. Interpreter and client
connection
2. Client trusting
interpreter
3. Interpreter knowing
client in a small
community

Therapist   Client

THERAPIST AND CLIENT
1. Cultural impact on therapist and
client relationship
2. Effect of therapist and client
relationship on interpreter

TRIADIC RELATIONSHIP
1. Interpreter part of
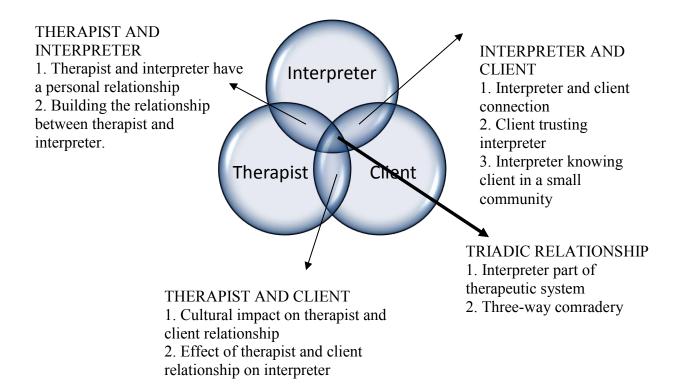therapeutic system
2. Three-way comradery

Figure 1. Venn Diagram illustrating the relationships among therapist, interpreter, and refugee

client.

Table 1

Themes, Subthemes, and Quotes

Main Theme	Subthemes	Quotes
Triadic relationship among therapist, interpreter, and client	**Interpreter part of therapeutic system**	T1 42 "she was really became like part of the therapy session" T1 42 "she was really became like part of the therapy session and we, the three of us actually, would get, would become engaged in a conversation." T2 46 "not just as only a voice, but as somebody who is a part of the, the relationship that the three of us have." T1 50 "felt like a three-way conversation. I: Mmm P: Which was very helpful for me and, um, I think it was really helpful for the client." T1 124 "the interpreter's really part of the system for you in therapy. P: Yeah. Or I try to make it. I don't think it works if the interpreter is not." T2 134 "Yeah. Not part of the therapeutic work whether it's doing therapy or the refugee health screener." T1 338 "sort of like summing up for the interpreter [laughs] you know will we did talk about this last week and I wanting so I'm asking this question it's because I'm referring to...you know sort of giving the interpreter a head's up so the interpreter could interpret the question in the context of which…you know…I mean it from something from previous conversations from previous sessions. So because if the interpreter was not aware I know that that's going to have an impact on how they're going to ask the question." I1 288 "I think because there are times where I have to cover up for an interpreter who works for the same patient and then you show up and you're like what is that all. So you have all these questions in your head trying to understand what's going on but it's really hard so you're not familiar with anything because I think once, um, when the three have, um, seen each other frequently." I1 296 "So you know what's going on as well. It seems like that's important"

I1 341 "be consistent with the same interpreter. I think that would be a lot, pretty easier and also, um, if you work with an interpreter has not been in the appointment just give them like a head's up on what's going on so they're not like lost."

Three-way comradery	T1 325 "? There's just a feeling like of [laugh] comradery sort of in the…you know that we're all in this together. You know? Even though the interpreter is interpreting I get that the interpreter gets it. we can all kind of laugh or cry or whatever with one another. Uh…that there's a sense…I…there's a sense that I…I guess a sense that I really trust that this interpreter is…even when…even when we can laugh about the difficulty [laughs] sometimes in trying to interpret correctly, but there's a sense sort of that we're all on the same page."
	T1 378 "The client responded and so we had a three-way conversation about that and it was okay."
	T1 406 "I said "Well, what do you think?" to the client and so they're going back and forth"
	T1 408 "I asked the interpreter what…what are those classes like and are they just for Bhutanese or, you know? Where's he coming from. You know? Like how has he organized these things and she said, "Yes. They're just for the Bhutanese community. I asked her what his background was and what his training was and she seemed extraordinarily well qualified"
	T1 412 ", "What do you think? Do you think it would be helpful? Do you want information?" So…sure. She was really interested so the two of them exchanged some [laughs]. So I was…[laughs]"
	T3 "we got, you know, good at taking turns."
	T3 132 "and they, and then they say to me, you know, I just explained to the client that, you know, that I'm here to interpret and I will interpret everything that is said in this room."
	T3 153 "Then they tell me kind of what's going on and they'll let me know and, uh, explain. I just explained to the client that…you know. So that was I think that was always very helpful when they could, you know, maintain that, um,"
	T2 43 "that she will then go back and forth a little bit and then turn to me and share with me what she has been talking about."

T2 99 "you know, so she's not. She never, um, just engages with me and leaves the patient to the side, but she will…I'll hear her say something and then she'll say to me, "I just asked if it's okay if I tell you this." And then she'll tell me something about Arabic culture."

T1 50 "felt like a three-way conversation."
T3 57 "And so if you have kind of three people who are all kind of getting to know each other and each other's style then everybody you know did a little bit better. Um or got more effective."

T3 60 ": Because the clients would understand, you know, my style and the interpreter's style and…um…you know…we got, you know, good at taking turns. That kind of thing"

I1 291 "when the three have, um, seen each other frequently. The language is very important, that's another one, um, if all of you understand each other very well it makes it very easy"

I3 176 "I: And do you feel you in some ways represent them and help them build trust?
P: Yeah, because I said I'm the patient's voice. When I enter the room I am the patient's voice and at the same time the counselor's voice as well. Yeah"

I2 196 "I try to a little bit stay a little bit far, you know, and let the provider or the client, um, have connection like connect themselves"

I2 230 "me , um, I will be speaking in the first person, you know, so don't say "can you tell her that I said this""

I2 222 "sometimes I just have to by my facial expression or by my, um, let's say behavior, I try to let them know that you should look at the provider. You should not look at me. You should not address the question to me, you know. So sometimes I try to look down if they're looking at me and just talk so that way they'll be like, oh so if you're not looking at me than she's the one or he's the one who's looking at me so I should be looking at the provider not you. So just small reminders not even you don't have to talk to remind them you can, just the way you stand, the way you look down when they're looking at you. They may be like, oh, just small thing can remind them of what you told them so like you always have to look at the provider when talking not me"

		I1 225 "So just be like you know just listen to what the counselor said and, you know, make sure you mention that to the counselor. They might have a better idea of what to do. Yeah. That's the best way to handle it."
		I3 144 "…I believe the client both client and counselor have trust in me, um"
		I3 146 "I believe both client and counselor have trust in me that I'm giving reliable messages."
		I1 285 "Yeah. I think if the whole three, the interpreter, the provider, and the patient all have an idea of what's going on it makes it very easy."
		I1 292 "The language is very important, that's another one, um, if all of you understand each other very well it makes it very easy and"
Interpreter and client relationship	**Interpreter and client connection**	T1 195 "I am absolutely sure now how they interpret, the depth of their interpretation, however in their language, in their culture, that that has an impact on what the client is saying back and how engaged the client feels" I2 151 "So do you find yourself building relationships over time or…? P: Not really because I try to keep boundaries, um, this is very important in my job because it's a job where it's very easy to build a relationship with somebody. Very easy because you get to know somebody, you get to talk to him, you get to ask him questions through, you know, the doctor or a provider gets to ask questions through you so he sometimes or she thinks you're the one who asked. So 'cause he got to understand the question through you so sometimes it may be hard, some people may want to get to know you better, get to know you more and you may be like "Um…" I2 179 ": They do and it's actually protecting myself because that way they don't ask me more questions. As soon as we're done, it's over so that helps to keep, you know, prevent myself from forming some kind of close relationship with clients." I1 307 "you know we're taught to not have like don't talk to them in the lobby, don't, um, engage in, um, conversations that are not necessary, but the African culture that's how somebody trusts you." T1 46 "Uh… it really helped me understand the client's

perspective, but also helped that she and the client seemed to get along really, really well."

T1 49 "So they, she also wanted her to be interpreting. You know? She requested her . So they had a really positive relationship . So, she could be open"

T1 66 "I think it's, it's helpful if there's a relationship between the interpreter and, and client. I think if something has been built over time."

T1 131 "and the interpreter is…um…I can feel as they have become more comfortable the whole thing is
more comfortable"

T3 420 "They started making that connection, they start noticing some benefit, um, and if they can have, you know, if they're comfortable with the interpreter, then you can, you know, you can, then it just, it's everything is more effective for everybody. You can see that they're, you know, more comfortable."

T3 410 "Yeah. I think…well I think it's a matter of degree of comfort, you know, for the client."

T3 420 "Yeah. So, um, you know, matter of degrees of comfort. I think there are some who, some who, you know they start, you know, getting used to"

T1 82 "But in the real world…I think in the real world the relationship between the patient and the interpreter, I think makes a huge difference and I can…and I've seen that. I've seen that in…in…with clients."

T1 66 "I think it's, it's helpful if there's a relationship between the interpreter and, and client. I think if something has been built over time."

I3 166 "do you feel like you build that relationship as well with the client?
P: Mmm…somehow yes, somehow yeah. Somehow. Especially when I do interpretation same client for every appointment."

T1 49 "she also wanted her to be interpreting. You know? She requested her"

T3 54 "sometimes patients or clients would ask for, would say "Oh

Jee I'd really like it if you know so and so could interpret." and we could make that request that they couldn't always fulfill it but they would try their best to do it,"

T3 70 "would be, um, frequently more, frequently one interpreter over another you know, per…generally per client request"

T2 55 "know specifically that the client will only have her as the interpreter and if she's not available, the client will not come."

T2 119 ". And the fact that she's requested that she only have Wafa as an interpreter makes me think that she really experiences a support as well."

T1 349 "it's great because the same interpreters show up with the person which is great"

T1 489 "I would encourage if the client is comfortable with the…I mean I don't know how you could do that, but I just think it's better if you have the same…as long as it works out for everybody, I think having the same interpreter is really helpful."

I3 166 "do you feel like you build that relationship as well with the client?
P: Mmm…somehow yes, somehow yeah. Somehow. Especially when I do interpretation same client for every appointment."

T1 86 "That when they have a different interpreter they seem to behave differently."

T1 135 "whereas before the client was not open to talking very much at all about the roles and limitations in her relationship and what I was seeing as gender limitations in relationships . And now she is much more open and I don't know, somehow it…it seems to be something that the three of us can share in a way, can laugh. And it just seems to help create a more…an easier atmosphere for the client."

I3 170 "Mmhmm. Yeah. And so do you think that that's um what do you think (I'm thinking) SO building that relationship with them, how do you think that impacts their counseling? Do you think it's important?
P: I think it's important for the counseling because as I said they have trust in provider and in interpreter as well so and they feel very comfort to share their story and their concern and all issues when they have this trust in somebody in who represents them."

I1 33 ": I think most of the clients that we, um, they feel comfortable if they see the same person over and over again. They tend to become more open and not, you know, hide some information 'cause, um, realize, not realize, but from what I hear from the client if let's say I'm working with a patient and then the next time I'm not available and they bring somebody else, what the client will tell me the next time is "I didn't feel comfortable saying some things so I didn't say much" and sometimes they tend, they might lie just to like not be open because they're not comfortable with whoever is there."

T2 58 "So I think the client sees her as a real, real big support."

T2 120 "Wafa as an interpreter makes me think that she really experiences a support as well."

I1 68 "I: No, I get it. Yeah. So you're like, it's almost like you're like a rock for them in therapy.
P: Yeah.
I: That person, so…
P: So their foundation. She's there for me. Yeah. That's the way I feel."

T2 116 "I can't say for sure, but from watching her I would imagine that she feels very validated, uh, with, because sometimes I'll be asking questions and I'll say, "Is this? I don't know? Is this what would be expected in your culture?" and she'll kind of look to Wafa and I think she feels validated by that"

I2 219 "counseling sessions because it's different, it's a little bit different because it's easier for the client to look at you as the interpreter 'cause you're sad, you need help and they look at me, they ask me questions and I just interpret"

I2 320 "Sometimes they know, but as an interpreter I just have to, yeah, yeah, because I've been living with people like these, like them, people like African, lived with them all my life so I know what a problem, what the problem is by the way he speaks by the way he looked, I know what the problem is, but I cannot step in and say so I just interpret."

I1 40 "So it sounds like you feel a real connection to most of the clients that you see in counseling.
P: Yes. I do."

Client trusting interpreter	I1 60 "More like a, um, trust. How do you say it? Because most clients that I work for, the way I feel about it is, first they have to be, to feel comfortable with you. I don't know how to say that. For them to trust you. So I feel like if they trust me then, um, they won't be more than likely to not be open." I1 300 "Trust. I: Trust P: Trust is the number one thing. If a patient doesn't trust you, you will make your interpreting very difficult. They have to trust you. That's the number one thing." I1 315 "Trust is important. Forget about the language. Trust, if they don't trust you, I've seen interpreters, um losing patients because of that." I1 414 "But one thing I always insist, make sure the patient trusts you. You get more information." I1 414 "But one thing I always insist, make sure the patient trusts you. You get more information." I1 215 "I make sure that the client feels comfortable with me so" I1 304 "And how do build that trust? Do you know? P: I don't know how I do it to be honest with you, but, um, I think you just be yourself." I1 305 "One thing I've realized with the clients, be an African. Don't show up and you talk about, um, because you know we're taught to not have like don't talk to them in the lobby, don't, um, engage in, um, conversations that are not necessary, but the African culture that's how somebody trusts you. With "HI. How are you? How's your family. How is everything going?" That's how they trust you, but if you are stand, not I won't say standoffish, but if you just don't' talk to them until the provider is there then that's a problem. So you have to somewhat engage them in, um, conversations, um, tell them who you are, where you're from and if they're families you can also be like, hey I have family too and, um, that's how you build it. I: Mmm P: Yeah. Being more friendly." I3 149 "when they are, when the counselor asks questions to the client and the client answers the questions that shows that the full message, accurate message was given to the client so I think that

builds the trust and professionalism as well."

I2 191 "like sit down, you know, not stand up when everybody is interpreting. To try to put myself on the same level as the client. That way he feels or she feels comfortable, you know. She feels that I am not over anybody. I'm not over her or him. I'm not over the doctor or the provider. I am just there to make the conversation go on so I try to, uh let's say sit a little behind, not in the middle of, you know, the provider and the client. I try to a little bit stay a little bit far, you know, and let the provider or the client, um, have connection like connect themselves and be there as just the language, um, channel. So that's what I try to do all the time. yeah"

I2 202 ": And do you feel that's important for them to be comfortable with you?
P: That's very important for them because they need to feel that no one is lording over them, you know."

I2 211 "Yeah. So I try to be discreet. I you say "how do you feel today?" even your posture I try to, you know "how do you feel today?" [soft tone] so that way it's like something you're , you're winning him a little bit, you know, you're letting him express or her express herself freely so, um, yeah."

I1 320 "I think because they were not so friendly and, um, some were judgmental. They don't like that if they feel like they, um, that you're superior than them then they tend not to do well with you, you know."

I1 133 "That' why they feel comfortable when I interpret for them. They're like, you're not going to lie to me. You're on my side."
T1 68 "always a question in my mind especially early on and, and when I first meet a client and the interpreter. I always have this feeling, no, always have this question, "Is this client comfortable with this person?"

T1 92 "Well I'm trying to honestly I try to assess for that. You know, I'm always looking for…um…indicators. Is this person comfortable with the interpreter?"

T1 274 "Is that…it's the other thing that goes through my mind about I wonder how that is. I don't worry about so much about the interpreter, but I do worry about sharing that, you know, that…the degree of comfort…the comfort level of the client to share."

	T1 74 "you know there's always this feeling that, am I getting the information that I really need or that the client really wants to say. Let's put it that way, not that I need. What the client wants to…to…um…um…provide or need to say or just it truly reflect where they are. How much influence is the presence of this person?"
	T1 86 "And I can't say, 'because there's no way for me to say…to pull the client aside and say "are you comfortable with this person?"
	T1 86 "And I can't say, 'because there's no way for me to say…to pull the client aside and say "are you comfortable with this person?" I: Right. Yeah… P: So I, you know, I can never know. It's a place of discomfort in me."
	T1 266 "comfortable here? You know? How do you know one another if you do?"
	T1 271 "Um…are you gonna see one another at church on Sunday and what is that going to be like for…you know…or whatever community gatherings."
	T1 72 "Culturally is it appropriate to have a female? Culturally, is it appropriate to have a male?"
Interpreter knowing client in a small community	T1 228 "the interpreter was- knew a lot about what was going on"
	T1 228 ", the interpreter was- knew a lot about what was going on and shared information with me, but t um …"
	T1 231 "Knew the patient outside of therapy. I: Okay P: And knew what was going on. Actually she was very involved with the whole family."
	T3 94 "I'm hear interpreter, yes I saw you…I interpreted for you at a medical appointment"
	T3 97 "Or maybe they know each other outside of the clinic."
	T3 146 "they know them from another setting or something like that and they start getting caught up in,"

I1 248 "Nice. So did you end up running into some of the people you had interpreting for?

P: A lot of them. Yeah. I saw a lot of them.

I: And what was that like?

P: That was, that was good. They're like oh you're also showed up today! So, you know, when they see you in that, in a different setting they are very, um, it's not about the problems they have. It's more about like let's have fun. That was fun. It really was."

I1 255 "No. You're not like in that interpreting role. You know, you're not like, oh I have to interpret this. We're speaking the same language and yeah. It was fun. Yeah"

I1 215 "because sometimes in the hallway, like before you even, you know, before the providers call you in, you kind of have somewhat of an idea about what's going on because they might talk to you about it or even after the therapy session, um, they might want to talk to you more about it. So you feel like, um, your role is not only an interpreter but you're like the other counselor where you have to give them your ears and listen to what they have to say. You might not advise them on what to do, but sometimes they just need, um, ears to, somebody to hear them. Yeah"

T1 282 "I do. you know more for the client's sake that even though…that I'm sure the interpreters sign a confidentiality statement. I mean obviously they have to, but I do…but still the client knows they know, they know, they know. They have husbands. Do they go home and say anything to their husband or their sister or their…you know."

T3 73 "two I think they sometimes they really had to restrain themselves, um, or they had to make clear what the client, you know, just I'm hear interpreter, yes I saw you…I interpreted for you at a medical appointment , but, you know, no I can't tell Sarah what happened in that medical appointment because sometimes they'd say that, you know, you were there, you know, you tell her. Like, no, I can't do that. Or maybe they know each other outside of the clinic."

T3 99 "And so they would, for them I think it could be tricky for them, you know, kind of observing and noticing that, you know, the limits and the boundaries and, um, offering reassurance that no, I'm, they – the interpreters are bound my confidentiality. As much as I am."

I2 129 "It is a bit hard because it's a very small community so

clients can be a little bit too demanding from the interpreter 'cause you have to like let them know beforehand your position, your why you're there."

I2 169 ": It is a very small community so the more I repeat the more serious I look and the more, uh, let's say distant they're going to be, they're going to know oh this is his job. This is his job and I'm not gonna, you know, involve myself into his, meddle myself into his life, because this is his job, that's what he's doing. So I try to reinforce these boundaries every single day. Like there's people that I've been introducing myself like fifty times and they're like, "We know! We Know!""

I2 131 "So they know you're not the one who helped them but they also know that without you they couldn't get the help they needed. They couldn't understand anything from the whole conversation so when we're done sometimes they want to ask me questions, "can you remind me what he meant or she meant by this and this?""

I2 141 "So that also can be a challenge living in a small community because people get to know you and they can try to call you even though you don't call them. I mean I don't give them my number but small communities they know how to get somebody's number so they can just call me and be like "what did the doctor say the other day" and I'm like "I don't remember. I just interpreted and I forgot. That's my job." So, yeah. That can be challenging."

I1 232 "I don't live in the same area they do. You know some interpreters do"
I2 285 "It does affect me, but more if it's somebody that I know"

I1 396 "And there also like if it's, um, a couple session you know sometimes it's, uh, you like the couple so much but because of things you hear you know, you might have like a different feeling about the person if you know what I mean. Yeah. Knowing what they, you know, it's hard.
I: You mean knowing other stuff outside of counseling?
P: Yeah
I: Yeah. From the community or…?
P: No. From counseling
I: From counseling
P: Yeah, what you know about them. Yeah. Like you have to be nice…"

I2 285 "what I do is whenever I receive a verification form and I

recognize the name and I see that it's mental I don't want to be involved."

I2 295 "So I try to whenever I know it's a relative or it's somebody that we're close friends I just say no I'm not going to be interpreting for that person. There are other interpreters that can come and interpret for them but I don't feel comfortable interpreting for that person. Why? Well I know the person."

I2 330 "So when I know that it's somebody that I know I don't' want to put myself in this kind of situation so I step out before everything happens."

I2 288 "So I may tend to step in, you know, say something, counsel, say "you shouldn't say that" you know or "you should say that. You should tell her this" because sometimes interpreters recognize the problem before counselors do because you know the background, you know what he went through, we all went through quite the same thing so, and you coped with it. You were able to overcome it. Why? You may have your own reasons or your own things that helped you that he or she doesn't have yet, so you may want to share so if it's somebody that you know the probability is you're going to step in, you're gonna really bad want to step in and say something."

I2 330 "So when I know that it's somebody that I know I don't' want to put myself in this kind of situation so I step out before everything happens."

I2 300 "I don't know him so that way I'm impartial. Yeah"

I1 385 "It was bad because the patient was very comfortable with me and, you know, they wanted to see me all through the process but it just got to a point where I just had to stop. Yeah. It was very emotional. It was hard not to show it. Yeah"

| Therapist and interpreter relationship | Therapist and interpreter have a personal relationship | T3 167 "Yeah. 'Cause I might see them at things like conferences or, um, or trainings or um, or we might partner on something." |
| | | T2 33 "So I know a little bit about her. I know that her children are in school in Lebanon and I know that she owned a…uh…a, um, store in Manchester so those things have come up, but I've had a relationship with her for – it will two years this summer that I have been using her as an interpreter, I don't know if that's the right term, but where she has been interpreting for this one particular patient." |

I2 109 "I think most of all is you know counselors are like friends, you know, they're like friends"

T2 19 ". It's al– it's strictly professional, but there's a personal side that we bring into the…relationship and the therapy"

T2 87 "I've always trusted her."

T1 333 "I guess I have to say what really helps is really getting to know the interpreter, familiarity with the interpreter and the interpreter being familiar with you."

T1 337 "I used to groan…you get a new…even if it was a difficult interpreter, if you get a new person each time I go, "Ugh" I felt like I was starting from scratch"

T1 354 "And I can picture myself groaning saying, "Oh, Cripe." You know? You really like have to start. It's like starting therapy sessions all over again."

T1 202 "you just know that you're going to have a more- I'll see them in the lobby and go "Great it's so and so.""

T1 393 "you build rapport with the interpreter in a way. You know. It's different, but building rapport with the interpreter really helps."

T2 21 "And it's always, and whenever we deviate from the strict therapy content it's for me it's always in the service of therapy – of the therapy."

T1 456 "you'll build the relationship over time, to expect to be awkward."

T1 518 "there is a relationship that you have with the interpreter that is…is important too. And I'm less clear about how I do that. That just sort of seems to come over time."

I1 12 "I think I get to know the counselors more personally, you know, like not personal, but how do you say it, feel more comfortable working with the same counselor over and over,"

T1 175 "Yeah. As I got used…as I got used to it, it became easier to have the third person in the room."

T2 87 "Maybe a little more comfort as we've worked together for longer."

T2 92 "think so, but it was never, it was never uneasy, but now it feels very easy."

T1 200 "And you have to trust the interpreter.
P: And I have to trust that they are- right! And so that trust is built over time and experience."

T3 13 "you know when you work with some of the same interpreters over and over again, which, which did happen"

T3 28 "they you know they had some longevity and so I got to know some of them and…and you know they get to know me as well so you know we kind of get a sense of each other's style."

T3 36 "And I think part of it was because I did get to work with them, you know, for kind of extended periods of time"

T3 161 "You know not get caught up with…let's say I know the interpreter I don't know just got married or something like that, you know, not start talking, to avoid talking to the interpreter about his or her personal life although after the session you know when the client is gone or if I happen to see them somewhere, you know, we might have that conversation just because, you know, we know each other"

T1 523 "You have different responses to peers that you're working with. They're people too. They're not robots like the guy who tried to sit behind the uh…you know?

I2 109 ", they know how to talk to other people and they don't' like need to be reminded all the time of how long should their statement be because they know that people, uh, I think that's how because every counselor that I've been working with never asks very long questions, you know. They ask few questions, short questions and let the patient talk. They don't talk a lot. They, they put an idea, they out a counsel there, a very short counsel so that the patient can remember easily. They don't talk a lot 'cause I think if they talk a lot then it can kind of, um, the patient won't remember. He'd be like, that was a long sentence I cannot even know, I cannot even know in short what it meant. But they try to like put their counsel short so that the patient can remember so that makes things easier for me 'cause I put it in his language or her language that short and most of the time I realize that when I

interpret these counsels, these short counsels, the patient repeats the counsels. So let's say go to bed early and I say go to bed early, most of the patients are like "Oh so I should go to bed early" that stays in their mind so when he goes home he knows what to do immediately. So that also helps, helps a lot when I'm interpreting form the counselor – keeping their questions, especially statements short."

T2 25 ": So when we were talking about the relationships that we as mothers have with our sons and our daughters, it was because the patient was talking about her relationship with her sons and I was trying to normalize it"

T2 28 "we had a, probably, a five to seven, ten minute conversation at the end of the session, towards the end of the session, but about our experiences as mothers of our sons."

T1 43 "we could go back and forth, and I could actually ask for confirmation and I'd say to the client, you know, "would you mind if I ask her a question." and I'd say "could you tell me from your experience is this how it was for you?""

T2 21 "and specifically on Friday we were talking about being the mothers of daughters and the mothers of sons"

T2 104 "but that even her son who has been raised here is now, uh, has a little bit of the macho that, that is kind of stereotypical of Arab men. And she said, "I don't know how that happened." So her point was to just further the conversation that we were having about having, what it's like to be a mother of a son in the United States, um, an Arabic son. So she added that in."

T1 460 "because you have to depend on this person that you have no idea what they're expertise is. You have no idea. You don't know who they are."

T1 222 "when you speak with interpreters outside of therapy sessions?
P: Mmm…I've never done that. [long pause] Maybe, you know what, I don't think so. I'd have to say probably no."

Building the relationship between therapist	T3 117 "of developed that trust that you knew how well they were interpreting? P: Oh yeah. I, uh, yeah definitely there were, there were some that just, um, felt, yeah. Yup, that I knew were you know doing a good job, um, and you know I'd known them for maybe a period of two

and interpreter		or three years at that point knew that they were competent"
		T3 1117 "I think when the interpreter can say, can come in and say you know acknowledge what the role is and be able to articulate that and say it, you know, I'm here, this is, you know. I'm here to interpret. I'm going to be interpreting for so and so, um, and then they also, you know, this is like the initial session, right. Um…they do a pre, um, pre session, I guess, before they actually start the session, but a, uh, like an orientation, you know. So the interpreter will also explain to the client, you know, I'm so and so. I'm from the Language Bank, you know. They always have their ID on them, you know, and they act professionally."
		T3 103 "so having an interpreter who understands that [professionalism] was really, really helpful."
		T3 117 "And that always. I think that always helped a lot when they weren't, when they were able to sort of observe that, observe that boundary or limit ."
		T2 39 "extraordinarily professional and she also brings herself into the room."
		T3 152 "They would say, you know, to the client, um, remember I', just here to interpret, you know."
Therapist and client relationship	**Cultural Impact on therapist and client relationship**	I2 267 "So sometimes I have to step up and say, um, that's the culture. When you're talking to somebody, especially when you're a woman they don't like to use their eyes, they don't like to look at somebody. Sometimes they just look down and so they have to know sometimes I just say that and mention it and it eases the conversation because the provider won't think that "why isn't she looking at me? Is she hiding something? Or is there something wrong with me that she's afraid of? Why is she not looking at me?"
		I3 82 "That's most of the time. Maybe as you do more visits with the client you gonna see some changes, but for like the first like five visits you're gonna do with the new patient no one gonna make eye contact so just pay attention when you get new clients. No one gonna do eye contact."
		I1 139 "Yeah. It depends on how, um, how do you say it, how. Oh god. How can I say it? Providers who've travelled are, um, are more…how do I say it? It's hard. I won't say open, but…more understanding."

I1 157 "Yeah, um, I remember working for a client a while back. That was the first time I started working and, um, it was concerning her, uh, and husband. You know um cheating going on, but, um, American culture, you know, it's different than our culture. Once you're married, you know, divorce is not an option in some places so I remember, um, the, the provider tried to tell the client, you know, there are other ways, you know, you can do things and it was hard because I knew where the women was coming from. I knew what she, she meant by, you know, like, um, it was sad because she was like you know I believe that god is going to make a way and he's going to come back to me but the reality of things…the way things were it looked like this was not going to happen and it was hard for the provider to explain this to the client because of that cultural difference."

I1 173 "It's very hard to put your point across because you find yourself repeating yourself over and over again and even when you explain, um, the difference like the cultural difference I think, um, for somebody who's never been, who's never grown up in that kind of environment it will be hard for them to understand why that is."

I1 178 "So you can see frustrations sometimes. Yeah with the providers, but I also understand where the client is coming from. Yeah. So cultural difference is a big thing."

I2 72 ", but sometimes I'll, the counselor asks a question and the patient answers or ask the patient to ask a question and the patient gives a statement. So that's how it is in many cultures, many African cultures. People don't like to ask questions the way a question should be asked. They give whole statement and the counselor or the, may be like where is the question. You've been giving me whole statement, but there's no question, he's not asking me questions. He's telling me a story. So that can be another thing because a lot of them that's the way they ask questions"

I2 257 "happen that not knowing the culture, you know, because yes you're a counselor but you grew up in this culture and she or he grew up in a totally different culture so I think culture is the main problem"

I2 262 "So for some counselors because they know that everybody though they're sick, sad, they look at, they look at you when they're speaking so she may be like, "why aren't you looking at

me?" you know? And the client may be offended a little bit so "who do you think you are? You want me to look at you when I'm talking to you? That's disrespectful. So you want me to be disrespectful." So that can be like he's not a good man, she's not a good woman. She wants me to be disrespectful. How is she going to help me."

I2 272 "So these mental questions can prevent a whole session to go well, you know, because when you're asking something to somebody and you already have a question going on in your mind like "why isn't she looking at me" you know that distracts you mentally. So…"

I2 305 "the culture because the culture is…I would repeat again culture is the main thing, you know, because they have their own culture and you may know how to counsel and that's what you're doing and that's a good thing, but sometimes culturally speaking like an elderly person may be or feel like he cannot be counseled or she cannot be counseled by a person younger than him or her."

I1 125 "because one thing I realized with the clients that I work for it's hard for them to trust, um, I don't want to say white people.
I: You can say it.
P: Yeah. It's hard for them to trust….
I: White people.
P: Basically like white people.
I: Yeah
P: Because they're not used to, um, they're not used to them, you know. They're used to their black people."

T1 296 "So we didn't. But, but all of those things I didn't know whether maybe that's just you don't talk about it. You know? Maybe that's just a cultural thing or maybe she didn't want to talk about it with me. Or…or was she embarrassed. Or…you know? I don't know."

Effect of therapist and client relationship on interpreter	I1 109 "Than when, um, the relationship between the counselor and client they don't know each other very well, there tend to be complications."
	I1 100 "Oh, okay. I get it. What makes it easy for me is like when, um, is when the client and the counselor have some sort of a connection where, um, they're like friends, but not really, if you know what I mean."
	I1 104 "Um, when I work with clients who are very familiar and very comfortable with the counselor there tend to be more, um,

positive things, you know. Um, like they'd be smiling or laughing or make jokes about things. Um, so when there is a good relationship between the client and the counselor it makes your job way easier."

I1 117 "I think when a client and a counselor has this good relationship, very open; they tend to be things to tend to end well."

I1 112 "It's more challenging because I, sometimes you know what the client wants to say, but they might tell you, like, don't say that. Did you say that because I don't feel comfortable saying that."

I1 144 "Mmhmm. So it sounds like for you how the counselor relates to the client really impacts how you work with the counselor.
P: Yes
I: Right. Yeah.
P: It does"

I1 325 "I think what I can tell them is, um, be on the same level as them. Be friendly, engage them into, um, things like I guess a little bit personal but not too personal. Yeah. That's how they gain their trust."

I2 92 "like if it's a parent who has kids, sometimes the kids come with the parent and the way the counselor, many counselors they try to keep the kids busy by giving them some things to play, you know some toys to play with, this makes the parents feel, this is like a burden that's coming out of the parent's head. It's like "I'm not alone in this. Somebody is trying to help me and not only me but is trying to also make the kids comfortable." So that makes them, it's like a huge weight that is coming off their shoulders so that is something that I, uh, appreciate as an interpreter because it makes things easier. It makes the parent not have too much concerning his mind when he's talking because if he's thinking about the kids but if he looks at the kids and he's like the kids are happy that makes him feel comfortable or her comfortable."

I2 104 "When you see the counselor showing empathy and also supporting the family and not just the person.
P: I know, from that moment on I know things are going to be good. I know this is going in a good place. Yeah. Yeah"

I2 309 "So it all has to do with your demeanor I can say, like the way you begin the whole thing, trying to become friends, not

friend friend, but trying to make the person feel that you're doing your job, you're trying to help, yeah,"

I3 194 "I think you do your job as, you do what you're supposed to do because you're not in charge of some of their needs, but you do refer them to where, to people who can help them with those so I guess you do what you're supposed to do."

I3 160 "the other difference I can say are the counselor sees the client like he on weekly or on weekly basis so they build like kind of relationship,"

T1 218 "They can laugh because it's hard for you to say…
 I: They know as well…
P: They know you're trying to share a concept that's just hard to interpret because [inaudible] sometimes."

T3 328 "really pay attention I think also to body language. Um…because you know, things can get lost in the, in the, in the translation, right? Um, and so since we observe a lot by body language and facial expressions and you know, don't discount that just because someone is interpreting for you. I think there is a temptation to, um…to not, to…we, I have to back up. At least at the mental health center what I try to do now kind of all the time is concurrent documentation so trying to document what is going on as we go along"

T3 349 "You've got to be attentive and you'll always want to watch, you know, what they're, what they're kind of what, their physical responses to things as well. So I think you know that's important."

T2 143 "you can't have the relationship because I can't talk to them"

Appendix A
Recruitment Letter for Foreign Language Interpreters

Dear [contact person],

I am sending a request for your assistance with a potentially important qualitative study conducted at Antioch University New England by me as part of my dissertation requirement of my doctoral degree in Marriage and Family Therapy. I will be focusing on the perceptions of relationships between foreign language interpreters and mental health professionals in counseling sessions. I am interested in interviewing foreign language interpreters who have interpreted for counseling sessions.

You can help me by forwarding the information of the study to any interpreters who may choose to voluntarily participate in the study. The interpreters will be asked to engage in one in-depth interview about their experience. The identities of the interpreters will be kept confidential and will not be identifiable in any publications or presentations resulting from this research.

We do not anticipate any risks to the interpreters involved in this study, although the study has some potential benefits. First, it can help to better inform both interpreters and mental health professionals working with refugee clients in counseling. Second, it can lay the groundwork for future research on ways to increase the effectiveness of mental health counseling when working with foreign language clients. All information gathered by me will be confidential and kept in a locked cabinet.

We hope that you will invite interpreters to participate in this study by forwarding this email to them or giving them my contact information. Interpreters who are interested in participating in this study should contact me at xxxxxxxxxx or (xxx) xxx-xxxx.

This study has been approved by the Antioch University New England Institutional Review Board.

If you have any questions about this study, please feel free to contact the principal investigator, Janet Robertson, M.A at xxxxxxxxxx.

Sincerely,

Janet Robertson (doctoral student)
Email: xxxxxxxxx

Marriage and Family Therapy Doctoral Program
Antioch University New England

Appendix B
Interpreter Demographics Questionnaire

Please complete the following form. The answers will contribute to the descriptive aspect of the study and will assist the researcher in understanding your responses to the interview questions. This form will be kept confidential and will be assigned a code number for referral. You may use the back of the form if needed.

What is your name? _____

In what year were you born? _____

In what state do you currently live? _____

In what country you were born? _____

Did you arrive in the United States as an immigrant or refugee? _____

What is your primary occupation? _____

What is your highest completed diploma or degree? _____

How many years have you been working as an interpreter? _____

In what languages do you interpret? _____

Do you interpret in mental health visits? _____

In approximately how many therapy sessions have you interpreted? _____

Have you received training in mental health interpretation? _____

Do you interpret in medical visits? _____

Do you interpret in legal settings? _____

Have you interpreted for the same patient in both medical and mental health visits? _____

Thank you for your participation.

Appendix C
Therapist Demographics Questionnaire

Please complete the following form and return it with the survey. The answers will contribute to the descriptive aspect of the study and will assist the researcher in understanding your responses to the survey questions. This form will be kept confidential and will be assigned a code number for referral. You may use the back of the form if needed.

What is your name? _____

In what year were you born? _____

In what state do you currently live? _____

In what country you were born? _____

If you were born outside the United States, did you arrive as an immigrant or a refugee? _____

What is your primary occupation? _____

What degrees do you hold? _____

How many years have you been working as a therapist/counselor? _____

What licenses have you obtained? _____

In approximately how many therapy sessions have you used an interpreter? _____

Have you received training in working with interpreters in therapy? _____

How did you learn how to work with interpreters in therapy? _____

_____

Thank you for your participation.

Appendix D
Interpreter Interview Questions

1.   What have you experienced in your relationship with the counselor in mental health

sessions?

        a.   How do you think the client experienced the relationship?

2.   What were the elements on the relationship that were really useful?

        a.   How do you think things went for the client?

3.   What were the elements of the relationship that were challenging?

        a.   How do you think things went for the client?

Appendix E
Therapist Interview Questions

1.   What have you experienced in your relationship with the foreign language interpreter in

mental health sessions?

        a.   How do you think the client experienced the relationship?

2.   What were the elements on the relationship that were really useful?

        a.   How do you think things went for the client?

3.   What were the elements of the relationship that were challenging?

        a.   How do you think things went for the client?

Appendix F
IRB Approval

From: kclarke@antioch.edu
To: jrobertson@antioch.edu, kclarke@antioch.edu
Date: Thu, Feb 13, 2014 at 2:25 PM
Subject: Online IRB Application Approved:An Exploration of the Understanding of Relationships between Therapists, Refugee Clients and Interpreters in Therapy. February 13, 2014, 2:25 pm

Dear Janet Robertson ,
As Chair of the Institutional Review Board (IRB) for 'Antioch University New England, I am letting you know that the committee has reviewed your Ethics Application. Based on the information presented in your Ethics Application, your study has been approved.
Your data collection is approved from 02/17/2014 to 03/17/2014. If your data collection should extend beyond this time period, you are required to submit a Request for Extension Application to the IRB. Any changes in the protocol(s) for this study must be formally requested by submitting a request for amendment from the IRB committee. Any adverse event, should one occur during this study, must be reported immediately to the IRB committee. Please review the IRB forms available for these exceptional circumstances.
Sincerely,
Katherine Clarke

Appendix G
Informed Consent Form

The Experiences of Foreign Language Interpreters and Therapists in Therapy with Refugee
Clients
Investigator: Janet Robertson, M. A.

**A researcher at Antioch University New England is asking you to participate in an
interview concerning the experiences of interpreters and therapists working with refugee
clients in therapy.**
This study is utilizing a qualitative method in which participants are interviewed about
their experience on the interpreting in a mental health setting. If you choose to participate, you
will be asked to participate in an interview with the researcher that will take approximately 30
minutes to an hour. The researcher is willing to interview in a setting of your choice.

There are no anticipated risks in your participation in the research.
No compensation is being offered, however your participation will contribute to the
understanding of the experiences of foreign language interpreters and therapists working with
refugee patients. This will give you a chance for your voice to be heard and may contribute to
the improved care of refugee clients in therapy.

All participant responses will be confidential.
The information you provide will be stored confidentially by the researcher, and she will
be the only person with access to the information.

Your participation in the study is completely voluntary.
If you do decide to participate in the interview, you may withdraw your participation at
any time by contacting the researcher by email or phone. If you do choose to withdraw, all your
information and responses to the interview will be destroyed.

**If you have any questions about the study, you may contact Janet Robertson at (xxx)xxx-
xxxx or via email at xxxxxxxxxx.**

**If you have any questions about your rights as a research participant, you may contact Dr.
Katherine Clarke, Chair of the Antioch University New England Human Research
Committee, xxxxxxxxxx, or Melinda Treadwell, ANE Vice President for Academic Affairs,
xxxxxxxxxx.**

Appendix H
Bias Statement

My interest in the subject matter stems from my experience as an immigrant in the United

States and is further reinforced by my experience working with interpreters in therapy. I was

born in South Africa and moved to the United States when I was 17 years old. I moved with my

parents, my older brother, and younger sister. Factors affecting my family's quality of life

influenced my parents' decision to move us to the United States in 2000. My parents' reason for

our move involved the increased job and educational opportunities for us available in the United

States and the increased violence and crime building in South Africa at the time. These reasons

coincide with Khawaja and Mason's (2008) study on South African immigrants to Australia. In

their study, many South African immigrants felt emotionally torn while immigrating because

they still loved their home country, but wanted better opportunities for themselves. They

describe this identification as a "reluctant immigrant" (p. 240), which added to their feelings of

confusion in the process. I think of myself as a reluctant immigrant because I didn't want to

leave my beautiful country and close friends, but knew that I would have a better life in the

United States.

When I did immigrate to America I was suddenly in a country where the food was

completely unfamiliar, my accent was strange, and I had lost my community. Even though

English is my first language, I struggled to relate to my classmates and friends due to differences

in words and accents. As an adolescent immigrant, I was constantly thinking about my word

choices and accent and worked hard to pick words that were more "American." I was also deeply

aware that every time I spoke, I was exposing my difference. I was telling them that I wasn't

one of them and the content of my words would be lost because of their focus on my accent. The

loss of community I felt was a result of my disconnection from my larger family. My experience

as an immigrant is unique to the experiences of many refugee families in America in that I had a choice in my resettlement. We chose to come to the United States and were able to do so financially. Many refugees are not so fortunate and may feel torn between the two cultures in a unique way.

My past work with refugee patients in a health clinic influenced my desire to pursue this research topic. I began to think about this idea based on two different interpreter experiences; one where an African female refugee interpreter was triggered in session by a client's story. She apologized profusely and said it was against policy and highly unprofessional. She was obviously distressed. We worked through it and she used this to connect with the client. The client felt connected and grew from the experience. Another experience involved an interpreter who developed such a strong connection with a client that he felt almost responsible for her success. When she tried calling him without a return phone call, she felt abandoned and started using another interpreter. I often wonder about the interpreter and the way in which he processed this loss. I could not help but notice the connection that emerged between client and interpreter and how this connection influenced the therapy process in multiple ways.