The Role of Interpreters in Psychotherapy With Refugees: An Exploratory Study

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Findings are presented from a narrative study that examined the use of interpreters in psychotherapy with refugees. Fifteen therapists and 15 interpreters were interviewed at 14 refugee mental health treatment centers in the United States. Core findings concerned the impact of interpreters on the therapeutic alliance, the complex emotional reactions that may arise within the therapy triad, the effects of interpreting on interpreters' own well-being, the multiple roles that interpreters play in addition to translating language, and the training and supervision needs of interpreters and of therapists who work with them. Implications of these findings for agencies that use interpreters in their clinical work with refugees are considered, and specific recommendations are made concerning the hiring, training, and support of interpreting staff.

This article describes the results of a recently completed study examining the use of interpreters in psychotherapy with political refugees. In contrast to refugees living in developing countries, where access to psychotherapy and other mental health services is extremely limited, refugees in the industrialized nations have comparatively greater access to the services of mental health professionals. In the United States, for example, mental health programs designed to serve refugee communities have been developed in most major cities. Although such programs vary in their target communities (e.g., Bosnians, Southeast Asians, torture survivors of any nationality), most refugee mental health programs share an emphasis on the provision of psychotherapy, together with other psychiatric and psychosocial services, to help clients recover from distress related to experiences of war and forced migration. Because few psychotherapists are conversant in the languages spoken by their refugee clients, mental health programs have traditionally relied on interpreters, often refugees themselves,

to facilitate communication between therapists and clients. As the number of refugee mental health programs has increased in recent years, so has the use of interpreters, without whom clinical services for refugees could not be provided.

The addition of an interpreter represents a significant alteration to the traditionally dyadic therapy relationship. The nature of that alteration—that is, the impact of interpreters on the process of psychotherapy with refugees—has been the focus of considerable clinical discussion (e.g., D. Kinzie, 1986; Pljevaljcic, 1993; Tribe, 1999; van der Veer, 1998; Westermeyer, 1990). However, researchers have yet to examine the numerous issues identified in the anecdotal reports of individual clinicians (Pljevaljcic, 1993; Tribe, 1999). In fact, we were unable to locate a single published study focused specifically on the use of interpreters with refugee clients. A small number of studies *have* examined the use of interpreters with nonrefugee clients, including nonrefugee immigrants to the United States and Great Britain (e.g., Raval, 1996; Sabin, 1975). Although we regard the findings of these studies as germane to the present research, two factors distinguish psychotherapy with political refugees from psychotherapy with other clients who might require an interpreter. The first factor is the prevalence among refugees of exposure to extreme violence and deprivation and the subsequent development of severe and persistent psychological trauma (J. Kinzie, Sack, Angell, Clark, & Ben, 1989; Weine et al., 1998). The second factor is the experience of multiple losses—of social networks, personal possessions, valued social roles, and environmental mastery—endemic among people forcibly displaced

from their home and community (K. Miller, Worthington, Muzurovic, Tipping, & Goldman, 2002). There is therefore a strong likelihood that interpreters working with refugee clients will be involved with therapeutic processes that are emotionally very intense and that involve the challenging task of interpreting stories of trauma, separation, and loss that are likely to echo similar experiences in their own lives.

Because of the dearth of research in this area, little is known about the ways interpreters may be affected by the stories they hear on a daily basis. More generally, we still have a limited understanding of how the use of interpreters may affect either the process or the outcome of therapy with refugee clients. Although clinical reports have provided experiential accounts of psychotherapeutic work with interpreters and have identified a range of issues germane to such work, there is a need for empirical research to complement the idiographic approach of individual authors writing about their experience in particular settings. Absent such research, there are few resources available to help therapists better understand the clinical roadblocks and challenges that may arise when interpreters are used, to assist program staff in identifying specific interpreter characteristics and practices that may facilitate or impede the therapy process, or to guide the development of empirically based interpreter training programs. When interpreters do receive formal training, it is often based on training models designed for medical or legal interpreters. In our view, this is problematic, as there are important differences in the training needs and work requirements of interpreters in these distinct settings. Unlike most legal and medical interpreting, interpreting in psychotherapy entails an ongoing relationship with the client, often over an extended period of time, and it involves the processing of highly charged emotional material related to war trauma and loss. This combination of long-term involvement and the interpretation of emotionally intense material sets mental health interpreting with refugees apart from interpreting in other settings and underscores the need for training models specific to the psychotherapy context.

The present study was designed to address this empirical gap by examining the use of interpreters from two critical perspectives: psychotherapists who use interpreters in their clinical work with refugees, and interpreters themselves, whose voices have been noticeably absent from the literature on the psychotherapeutic treatment of refugees. In view of the lack of prior research in this area, we adopted an exploratory approach to identify the critical variables germane to the hiring, training, supervision, and ongoing utilization of interpreters in psychotherapy with refugee clients. Banyard and Miller (1998) have discussed the value of inductive methodologies such as semistructured interviews in research on topics about which relatively little is known. In a similar vein, Dumka, Gonzales, Wood, and Formoso (1998) noted that qualitative, exploratory methods allow participants to identify the relevant variables in previously unstudied domains. In this way, qualitative methods can lay the groundwork for the subsequent development of empirically sound measures, such as questionnaires. Because so little research has been conducted on the use of interpreters in mental health settings, in general, and with refugees, in particular, we felt that an exploratory, inductive method would most effectively allow us to both examine in depth those issues identified within the clinical literature and identify other potentially important variables not previously discussed by individual clinicians.

In the present study, we had two primary aims. The first was to examine the salience across multiple settings and respondents of the key themes identified in the clinical literature. These include (a) the impact that interpreters may have on the therapy process, (b) the complex emotional reactions that arise within the therapy triad and the various ways these reactions are managed, (c) the multiple roles that interpreters play and the impact of these roles on the therapy process, (d) the impact on interpreters' well-being of the difficult work they do, and (e) the training and supervision needs of interpreters. Our second aim was to identify previously unexamined issues related to the use of interpreters in refugee mental health settings. Toward this end, and to shed additional light on the key issues just mentioned, we felt it was essential to interview interpreters as well as therapists in the present study. As suggested earlier, despite the critical contributions that interpreters make to the therapy process, their perspectives have been largely excluded from the literature on mental health services for refugees. It was our hope that by incorporating the voices of interpreters into the present study, we might attain a deeper understanding regarding the nature of their work and the challenges they encounter.

Method

Participants

A total of 15 therapists and 15 interpreters participated in the study, representing 10 torture treatment centers and four refugee mental health clinics in five states (California, Colorado, Illinois, Minnesota, and Pennsylvania). Participants

were initially contacted by a member of the research team, and the purpose and method of the study were explained. Of the 17 therapists contacted, 2 declined to participate. Ten female and 5 male therapists were interviewed, with a mean age of 43.50 years ($SD = 9.38$). All of the therapists were U.S. born and native English speakers. To avoid idiosyncratic experiences based on work with only one interpreter, we used an inclusion criterion that therapists must have worked with at least two different interpreters. Therapists in the study had worked with clients from various regions of the world, including Africa, Latin America, the Middle East, and Eastern Europe. Of the 17 interpreters we contacted, 2 declined to participate in the study. There were 14 women and 3 men, with a mean age of 36.00 years ($SD = 10.00$). Although our intent was to include a geographically diverse range of interpreters, we ended up with a restricted sample of 13 Eastern Europeans, all refugees themselves, and 2 native born Americans. The former came from Bosnia, Kosovo, Russia, the Ukraine, and Azerbaijan. The implications of this limited diversity in the interpreter sample are considered.

Measures

All participants were interviewed via semistructured interviews developed for this study. The therapist interview explored the impact of interpreters on the therapy process, perceptions of the interpreter's role in the therapy relationship, the impact of interpreting on interpreters' own well-being, challenges to working with interpreters, and recommended training issues for interpreters. The interpreter interview examined the training that interpreters had received, challenging and rewarding aspects of their work, their perceptions of the role of interpreters in the therapeutic process, the impact of interpreting on their own well-being, the availability and value of institutional support for their work, and areas in which they believed refugee mental health interpreters should receive training. Both interviews took about 45 min to complete. Interpreters received a stipend of $25 for their participation.

Procedure

Because the participants in this study lived in geographically distant regions of the United States, it was necessary to conduct many of the interviews by telephone. Local interviews were conducted in Kenneth E. Miller's research office or at the participant's work setting. Interviews were conducted by a licensed psychologist or a student trained in narrative research methods. Interviews were tape recorded and transcribed. Data were entered, coded, and analyzed with the qualitative software program NUD*IST (Version 4; Richards & Richards, 1997). We developed a set of codes using an inductive approach in which we identified themes (codes) by reading through the interview transcripts, creating a detailed code book, and revising the code book as new codes were identified. We identified 24 codes for the therapist data and 23 codes for the interpreter data. We assessed intercoder reliability separately for each sample, using the interrater reliability index (total agreements × number of coders/total coding instances). Interrater reliabilities were .70 (therapist data) and .84 (interpreter data).

Results

The Impact of Interpreters on the Therapy Process

Two primary themes emerged from the interviews regarding the impact of interpreters on the therapy process. The first concerns the impact of interpreters on the development of the therapeutic alliance, whereas the second relates to the complex emotional reactions that can arise within the therapeutic triad (client, interpreter, and therapist) and the possible impact of these emotional reactions on the therapy process.

Impact on the therapeutic alliance. The term *therapeutic alliance* refers to the working relationship that develops between therapist and client. More specifically, it connotes a positive, collaborative relationship based on trust and a shared commitment to the client's growth and healing. A strong therapeutic alliance is generally regarded as an essential component of effective psychotherapy, regardless of the theoretical orientation of the clinician (Lambert, 1992).

In considering the impact of an interpreter's presence on the development of a therapeutic alliance, it is first necessary to consider how best to conceptualize that alliance once an interpreter is added to the traditionally two-person therapy relationship. Is the critical alliance still the dyadic relationship that evolves over time between therapist and client? Or is the therapeutic alliance a *triadic* set of relationships that develop among all three individuals in the therapy office? Is the quality of the client's relationship with the interpreter germane to the success of the therapy? That is, is it important for some form of therapeutic alliance to develop between client and interpreter, and, if so, how does this alliance differ from that between client and therapist?

Participants' views on these questions reflected their stance on an underlying issue, which concerns what we have called *models of interpreting*. The term refers to the way participants understood the interpreter's role in the therapy process. For a few respondents (both therapists and interpreters), the interpreter was regarded essentially as a "black box" (Westermeyer, 1990), a translation "machine" whose personality and relationship with the client are not clinically significant unless they adversely interfere with the

therapy process. The focus is on developing the traditional therapist–client alliance, and the interpreter is expected to aim for a kind of invisibility during the session. This perspective is illustrated by the following quote from a therapist who explained his preference that interpreters use the first person (*I*) rather than the third person (*he* or *she*) when interpreting a client's words:

> For me it feels like I am able to connect more directly with the patient that way. It somewhat eliminates the person of the interpreter, although it is always a triad but in this way it minimizes the presence of the interpreter. For me, I want to have a direct connection with the patient.

The notion of "eliminating the person of the interpreter" frames the interpreter's presence as an unfortunate necessity, a potential obstacle to genuine therapeutic contact with the client. Although the interpreter is obviously not a machine, the goal is to minimize awareness of his or her presence, in effect transforming the interpreter into a kind of impersonal instrument that unobtrusively facilitates communication between therapist and client. For one therapist, the presence of the interpreter was experienced as a persistent intrusion into the therapy process; consequently, he preferred to eventually work without an interpreter, even if this meant a diminished capacity to communicate with the client:

> My rule of thumb is that I get the interpreter out of the room as fast as I can, as much as I said earlier that therapy turns on the nuances, there is a certain point after I have worked with somebody for a while and we have gotten to know each other and we have gotten the basic story, if they can understand half of what I am saying after a while and I can understand half of what they are saying, I tell the interpreter to leave.

In contrast to the "black box" perspective, most of the therapists and interpreters understood the interpreter's role in more relational terms. From this perspective, the interpreter is viewed as an integral part of a three-person alliance. Far from being invisible or dispensable, the interpreter is an important witness to the client's experience, and the gradual unfolding of the client's story reflects a growing sense of trust not only between client and therapist but also between client and interpreter. Therapists working from this perspective are more likely to solicit interpreters' thoughts about clinical material and are also more likely to rely on interpreters as cultural consultants who help them understand the cultural context of the client's experience and the specific cultural meanings of particular behaviors and metaphors.

The belief that the client–interpreter relationship is an important component of a triadic therapeutic alliance is evident in comments suggesting the importance of having the same individual interpret each session, to the point of actually canceling sessions if a interpreter is sick or out of town, despite the availability of a substitute interpreter. Similar comments were offered by several therapists, such as this woman, who works with survivors of torture:

> I think it would be really hard to have someone come in and just interpret because there seems to be something very important about the consistency, having the same interpreter, which suggests that they are doing more than translating language. If they were merely just interpreting what the client said, it seems like we could have anyone there on any given day and that is clearly not the case.

An American-born interpreter underscored the importance of the trust that develops within the interpreter–client relationship:

> I think if you put somebody else in as a substitute for a day or 2 days that it completely changes the dynamic of the therapy. It actually happened to us once. Someone [new] came in and it was almost like starting from ground zero because it took a very long time . . . to get the client to relax and discuss issues that were either painful or poignant. I think that that is something that is built over time, rather than just somebody that comes in and translates between languages.

The importance of trust within the interpreter–client relationship is readily understandable. Refugees, whose capacity for trust has often been diminished by their history of persecution, are invited to reveal their experiences of victimization, humiliation, and loss, not only to the therapist but to the interpreter as well. A survivor of wartime rape being treated in therapy shares her trauma with *two* individuals, both of whom become witnesses to the impact of her experience. As we discuss below, when clients feel supported and accepted by the interpreter as well as the therapist, the therapy process is facilitated; however, when clients perceive the interpreter as disinterested, dismissive, or judgmental, trust is diminished, and the healing process breaks down. One therapist, for example, described a situation in which an interpreter whose family escaped the war in Bosnia could not tolerate the intense stories of war-related violence she was hearing from therapy clients, who were also Bosnian war survivors. To defend

herself against the distressing feelings these stories aroused, the interpreter adopted a dismissive, almost casual tone as she translated the clients' words. As a result, clients felt she was minimizing the painful reality of what they had endured and implicitly judging them as weak for continuing to experience war-related trauma and grief. This perception reduced trust among clients and discouraged ongoing discussion of their experiences.

A relational view of the interpreter's role recognizes that because interpreters are normally the first point of contact for clients between sessions and in moments of crisis, they often become important to clients for reasons that transcend the actual interpreting work during the clinical hour. An interpreter from the former Soviet Union articulated this view, sharing a perspective widely held among the interpreters we interviewed:

> Being an interpreter to me is not just being a radio, "Ok, he said that, you said that. . . ." It is more than that. These people, when they come here, they have all these fears and anxiety and many of them have depression and PTSD. As interpreters we are somebody they are connected to because they feel, "Ok, this is the person I should hold on to because she is helping me, she is interpreting for me, and whenever something happens she is the person that I run to, whether I call or go or something."

It is quite common for clients to initially form a stronger attachment to the interpreter than the therapist. Although respondents offered a variety of reasons for this phenomenon, a critical factor seems to be that for many clients, interpreters play the role of *therapy conduit*. As the first point of contact for prospective clients, interpreters must normalize psychotherapy to clients from cultures in which psychological and psychiatric services are unfamiliar, frightening, or highly stigmatized. To accomplish this, they must understand and believe in the utility of therapy and must be able to form an empathic, reassuring connection with distressed individuals who are wary of seeking mental health treatment. Through this process, an interpreter–client relationship may begin to form prior to the client actually meeting the therapist. Most of the interpreters we interviewed understood and valued this role as a conduit to psychotherapy, as illustrated by this quote from a woman from the former Soviet Union:

> It is mostly the problem that our people, when you talk about psychiatry and psychology here, that for them that is something horrible. Because if you go to a psychiatrist there you are automatically labeled that

you are psychotic so that scares them. Many people, just because they don't understand what psychiatry and psychology mean here, they are reluctant even to seek help, although they need it . . . unless we do all the education and explaining to them that this is different.

In summary, the modal perception among participants (therapists and interpreters) was that the role of interpreter entails a great deal more than simply functioning as a sort of translation machine. Interpreters provide cultural guidance to therapists who lack familiarity with their clients' cultural background; they are conduits to therapy for clients who come from cultures in which therapy is unfamiliar or viewed negatively; they are often the first person to whom clients turn in times of crisis, because clients can communicate directly with interpreters and not with therapists who do not speak their language; and, for better or worse, the nature of their relationships with clients can have a significant impact on the therapy process. Although some therapists may prefer that interpreters aim for a kind of invisibility in session, it is evident that clients regard interpreters as anything but invisible. Clients often have strong emotional reactions to interpreters, often positive but sometimes quite negative. For example, one interpreter, a Bosnian woman who had been a physician in Sarajevo, described a situation in which a Bosnian Muslim client became verbally abusive to her over the course of several sessions, accusing her brother of being involved in the killing of several members of the client's family. In fact, the interpreter, a Bosnian Serb, had no brother, but the ethnic difference and the powerful reaction it evoked in the client made the development of trust impossible and thereby significantly impeded the therapy. To have regarded the interpreter simply as a black box in this case would have overlooked the very real and problematic interpersonal dynamics that were occurring.

We began this section by asking about the impact of interpreters on the therapeutic alliance. It is evident that the most immediate impact of the interpreter's presence is to alter the nature of the alliance itself. Therapists must concern themselves with developing relations of trust among all three members of the therapeutic triad. As we discuss below, tensions can arise in any of the components of this triad, and these tensions can create significant obstacles to the development of a supportive, constructive alliance.

The triadic nature of the therapeutic alliance notwithstanding, all of the therapists spoke about the ways an interpreter's presence affected their ability to

form a constructive working relationship with clients. There was a general consensus that having an interpreter present tended to make the development of the therapist–client relationship a more gradual process than is common in traditional dyadic therapy (i.e., without an interpreter). In fact, several therapists described a pattern in which clients initially formed a stronger bond with the interpreter, only gradually developing a comfortable relationship with the therapist. This pattern could be seen in the tendency of clients to initially make eye contact with, and speak primarily to, the interpreter, followed in time by a gradual shift in body language, so that eye contact and verbalizations were directed more and more frequently to the therapist. Most therapists eventually became comfortable with this process; however, several individuals acknowledged their initial discomfort at feeling excluded from the bond of trust that often formed between clients and interpreters during the initial phase of therapy. A psychodynamic therapist discussed this in terms of the shifting nature of the client's transference:

> One thing is that in terms of transference, there seems to be a lot of transference, really strong transference from the client to the interpreter, and sometimes I actually feel kind of left out, so that I am missing the transference to me, especially in the beginning.

Another therapist, who was working with a group of Bosnian youth with the assistance of an interpreter, described a similar reaction:

> The kids seem to relate very strongly to her [the interpreter] and not relate very much to me. I have been seeing over time that they started to seem more connected to me. And you know, I felt like I just had to, at a certain point I told myself, "Well, just be patient and do not take this personally and do not get triggered by this."

This pattern, in which the client's attachment forms initially with the interpreter and gradually broadens to also include the therapist, suggests that therapists working with interpreters must be patient while waiting for the therapist–client relationship to unfold, bearing in mind that the emergence of the therapist–client bond is often slower to form when work takes place within a triadic rather than a dyadic framework. The initial intensity of the client–interpreter relationship may arouse feelings of exclusion and uncertainty and even competitive feelings in the therapist toward the interpreter. One therapist related how he had initially felt excluded by the strong connection that formed quickly between a client and the interpreter,

both of whom came from rural towns in Bosnia. The therapist found himself describing his own rural background as a point of commonality and a means of entry into the client–interpreter relationship—a reasonable act of self-disclosure, yet also an expression of his discomfort at not being a part of the intimacy that had formed between the client and interpreter. It seems important to honor the natural process by which trust develops within the triadic framework, allowing for its evolution with the same patience that is essential in dyadic psychotherapy.

Complex emotional reactions.   There is a rich clinical literature examining the complex transference and countertransference reactions that commonly arise in psychotherapy with survivors of traumatic violence (e.g., McCann & Pearlman, 1990; L. Miller, 2001). In the present study, we were interested in examining the ways complex emotional reactions might arise within the triadic therapy relationship, so that we could better understand the types of powerful and potentially disruptive emotional and behavioral responses that might adversely affect the therapy process. Although we initially conceptualized such reactions using the psychoanalytic constructs of transference and countertransference, we eventually discarded these terms in favor of the more inclusive, less theoretically specific term *complex emotional reactions*. The terms *transference* and *countertransference* make sense within a therapy relationship in which there are two clearly defined roles, therapist and client. Once an interpreter is added, however, it is less clear how to apply these traditionally dyadic constructs to the myriad reactions that may arise within the triadic therapy situation. In addition, many of the intense emotional reactions reported by participants could not accurately be described as transferential (or countertransferential) in nature. For example, one response we heard several times concerned a client of one ethnicity distrusting an interpreter of another ethnic group on the basis of recent experiences of ethnic conflict between the two groups. There was no unconscious projection of early interpersonal schema in such experiences of trust; instead, the client's distrust was wholly conscious and fueled by recent traumatic events.

Therapist Reactions

In general, therapists were highly appreciative of the interpreters with whom they worked, both for the actual work of interpretation and for the various other roles they played. In addition, several therapists

spoke of how much they valued having an interpreter present to share the intensity of the client's emotional experience:

> I remember countless times when you would hear something that would just be like a punch in the gut, and there would just be this shock, you would think, "I could never hear something more shocking in my life." It was traumatizing . . . and having the interpreter there with you was so immensely comforting because you know that you could process it together. There was this implicit understanding between you that you had both witnessed something very profound.

Another therapist shared a similar opinion:

> I recall a time when I did EMDR with a particularly traumatized woman whose brothers had both been killed, one of them quite brutally. Initially, the interpreter thought it was quite odd, the eye movements and focused attention of the client. The client began to wail in the most intense way, expressing deep traumatic grief she had carried around for several years. I was actually quite glad, very appreciative really, to have the interpreter there with me. It made the intensity of the client's reaction easier to sit with, and I was glad to have someone with whom to process the experience after the session ended.

Although most of the therapists we interviewed felt positively about their experience with interpreters, most therapists had a least one story about an interpreter whose behavior had generated in them feelings of frustration or anger. Typically, this occurred in response to an interpreter inappropriately interjecting his or her opinion into the session or intervening directly with the client in some way the therapist found unhelpful. Though annoyed, most therapists understood these problematic behaviors as simply reflecting the need for better training for interpreters, many of whom were described as having an inadequate understanding of the nature and process of psychotherapy:

> There [were] a few times when I was working with an interpreter and I was asking about a particularly sensitive topic, and the interpreter stopped me and said, "Please don't ask her about that, that is going too far, you are going too deep, she is not ready for that," and I said essentially, "Well you are going to have to trust me as the therapist here that I will handle this in a delicate way, but I think it is important that we take this to the next level." And I had to convince the interpreter to actually do what I thought was therapeutically indicated.

Another therapist described a similar experience that occurred while she was working with a trauma-tized client who was dissociating in the session. The therapist met resistance from the interpreter when she asked a question meant to ground the client in the present situation:

> The interpreter said to the client, "Well, she wants me to ask you what color her shirt is. . . . I do not know why, that is really stupid." Well, it was frustrating as hell, and I had to stay completely grounded, and not let that show, because I did not want to trigger the client.

In other instances, therapists became distressed at what they perceived to be an interpreter's decision to interpret selectively, omitting certain aspects of a client's remarks. Here, a therapist shares her frustration at the impact of selective interpreting on a women's therapy group:

> We had an interpreter for our group who was not trained as an interpreter. She had a background in nursing, but she was not a very good interpreter. She would choose not to say certain things that she did not herself want to deal with, or she would make commentary on what other people were saying. . . . That was a really frustrating experience and I think it broke up the whole cohesiveness of the group.

Another common therapist reaction was feeling self-conscious when first working with an interpreter. Several therapists shared their initial experience of wondering how they were being perceived by the interpreter and noted that it felt peculiar to have their clinical work, ordinarily so private, observed by another person. For most of the therapists, however, this initial discomfort faded, and the experience of working with an interpreter came to be regarded as enjoyable.

Interpreter Reactions

When asked about emotional reactions they had experienced during therapy, including reactions to client or therapist behaviors that had made them uncomfortable, interpreters focused primarily on the emotional impact of hearing painful stories of war-related trauma and loss. One interpreter, a young Bosnian man, talked about the sadness he felt and the reexperiencing of his own traumatic memories that clients' stories sometimes triggered:

> It depends on the experience [that the client is describing] because I have some horrible experiences myself and that moment when people start to talk about close experiences as mine, I just go sad inside. It is just like you remember it alone. . . . You just feel sad about it. But in that moment, when somebody's talking about

that situation, you are not able to do something by yourself. It is for me the most worst situation in what I think can happen. It feels . . . like you are just coming back to, and visiting, that moment.

When therapists were asked about potentially problematic emotional reactions they had observed in the interpreters with whom they had worked, they generally indicated that such reactions were uncommon in the day-to-day course of their work. However, almost every therapist had at least one story about an interpreter who had been noticeably affected by the intensity of a client's story, particularly when that story resonated with the interpreter's own wartime experience. This was not necessarily regarded as problematic, however, unless it actively disrupted the session. In the following quote, we see from a therapist's perspective the impact on a female interpreter of hearing a client's story of rape:

> I had one interpreter start shaking. It was too much for her. The client had been raped, and it was a woman interpreter and a woman client, and it just . . . I don't know what it triggered in the interpreter. To my knowledge, she'd never been through anything like that. But it created a . . . I mean, I think this was transference . . . she just became incredibly upset and angry. And she started shaking because of the thought of a woman being raped. You know, she just . . . I've had that happen a couple times.

A similar experience was related from an interpreter's own perspective:

> I remember one woman who was raped and when she told me what happened I was crying. And I could not say anything so I had to wait until I stopped crying to translate. So the therapist could not know immediately what happened. So that was very hard and in that moment I felt like, it was not fair, I was weak. And after that I had a big discussion with the therapist and I realized it was not weakness, it is just a human reaction.

In the following quote, a female therapist describes a male interpreter's disruptive reaction to a female client's expression of love for him:

> I can think of one time very clearly . . . where the client developed a love transference toward the interpreter. It was very difficult for the interpreter because he was not trained in that; he was trained as a physician so he was uncomfortable with it, so he changed in the therapy room. He became sort of stilted for a while and sort of disconnected from her and he was very afraid of her transference toward him.

Despite the initially disruptive impact of some interpreters' reactions to distressing clinical material or uncomfortable interpersonal dynamics, most therapists said that they did not necessarily find such reactions problematic if they were not too extreme and if the interpreter was able to recognize and address their emotional response. For example, one therapist described an interpreter who had to leave a therapy group to find a private place to cry, in response to the group members' discussion of family members who had been killed or were still missing. The interpreter's willingness to process her reaction with the group transformed a disruptive moment into a positive, therapeutic experience for the whole group:

> One time . . . we were doing a [women's] group and one of the interpreters started crying and she had to get up and go to the bathroom for like, she was gone for 10 min . . . When she came back we did not say, "Now tell the group what you were feeling," but you know we talked about it a little, you know we were just kind of quiet and looking at her and just kind of waiting. And she said, "That happened to me and that reminded me of being with my children and I could not stand it and got so frightened all of a sudden." And the other women in the group felt instantly closer to her and that she was one of them. It was very profoundly powerful.

In describing complex emotional reactions among interpreters, we do *not* mean to imply that such reactions occurred frequently in our sample or that they argue against using individuals who are refugees themselves to interpret in psychotherapy with other refugees. As we discuss below, we believe the merits of using refugees as interpreters far outweigh the potential problems and that problematic reactions can often be avoided by paying careful attention to appropriate hiring criteria, by providing thorough training to new interpreters, and by ensuring that agency staff provide ongoing supervision to interpreting staff. A set of suggested hiring criteria are provided below, as are suggested foci for the training and supervision of interpreters.

The Impact of Interpreting on Interpreters' Well-Being

There is a debate among mental health providers who work with refugees regarding the appropriateness of using refugees as interpreters. The argument against this practice lies in the potential risk of retraumatizing interpreters who have their own history of war-related trauma and loss. The rationale for

using refugees as interpreters is threefold. First, because they share a common cultural background with their clients, interpreters who are refugees themselves can serve as cultural liaisons between client and therapist in ways that interpreters from the host society cannot. Second, a common concern of refugee clients is that their experience will not be adequately understood by someone who has not lived through it (K. Miller, 1998). Having an interpreter present who has shared some version of the client's experience seems to serve as a kind of reassurance, conveying to clients that they have an ally in the room who *does* know what they have been through and who can help the therapist to better understand their experience. Finally, a third rationale for using refugees as interpreters is purely pragmatic: Some refugee mental health agencies simply do not have access to anyone from outside of a refugee's own community who speaks the required language and is available to interpret.

To date, the debate regarding the appropriateness of having refugees interpret has not been informed by empirical data. Although the present study used a small sample that precludes reaching any definitive conclusions, our findings do speak to this issue. Although our data certainly affirm the reality that some refugee interpreters do experience an increase in short-term distress as a result of their work, the data also indicate that such reactions are relatively uncommon, are usually short-lived, and rarely cause disruption to the interpreters' lives outside of the clinic. This is not to minimize the reality of those times when interpreters are affected by the nature of their work. However, in only one instance did we hear (from a therapist) of an interpreter, himself a traumatized refugee, who became acutely distraught as a result of his work and had to discontinue working as an interpreter. Although it is important to note the occurrence of such experiences, it is also important to view them in context: In this study, all but one of the refugees who worked as interpreters described their work as stimulating, gratifying, and minimally disruptive to their overall well-being.

When we asked interpreters about the impact of their work on their own mental health, a consistent pattern emerged. Interpreters who were refugees themselves described experiencing a moderate increase in distress during the first few weeks or even months of their work, as they were exposed repeatedly to stories of violence and loss. Participants described feeling more anxious than usual, having intrusive thoughts about distressing stories that clients

had shared, and, in some instances, reexperiencing some of their own unresolved pain:

> In the beginning it was really rough, I mean really tough because I saw some things that happened over there . . . so in the beginning when I was listening to these stories and I was translating, I was putting myself in the same situation. You know, like I am there, and then on the way home, like I was a little bit nervous, I was reacting like a little bit faster, I would explode very fast because I think that those things that they told me, they were still in my brain, you know the stories they were telling me. They were still inside me.

Within a short time, however, most respondents had made an adjustment to their work. The moments of distress diminished considerably, as did the intrusion into their private lives of upsetting work-related thoughts and feelings. In addition to this gradual acclimation to the nature of their work, participants also described a variety of strategies they had developed to cope with the distress that interpreting periodically generated. These strategies included talking with therapists after sessions (something interpreters found very helpful, though inconsistently available), learning to sit with their feelings of distress, distracting themselves after work to get work-related thoughts out of their mind, turning to family and friends for support, and focusing on the importance of their work. For most interpreters, this was sufficient. In fact, with one exception, the interpreters we interviewed made clear that they did not perceive any adverse long-term mental health effects of their work. On the contrary, the majority of interpreters were quick to say that not only had the work not affected them negatively, it had actually enriched their lives, given them a helpful perspective on their own war-related experiences, and deepened their sense of compassion for the suffering of the clients with whom they worked.

The one exception to this positive evaluation was a Kosovar interpreter who worked with refugees from Kosovo. Not only did she report working an exceptional number of hours each week (well over 40), she was also the only interpreter in her agency who worked with Kosovars, and this had a somewhat isolating effect. In addition, as a recent arrival herself, she still lacked an adequate social support network. Taken together, these factors left her particularly vulnerable:

> I do not know, you know the stories are really painful. It happened to me a few weeks ago, I heard something, my brain just could not take it. I came back and I talked with my friend who is working with me and cried then

because it is hard. I mean, I did not have any trauma in the war, I was pretty lucky but I know how this looked because I saw that, you know, it is really hard. . . . I have another problem, I cannot wake up. I sleep very well and I just cannot wake up. These last few months when I started working so hard and I do not know, I am not taking therapy but I think I should. . . . I cry much more easily than before.

Although this woman's experience was unusual for our sample, it underscores several points regarding the hiring, training, and ongoing support of interpreters. The work of interpreting with refugee clients is challenging and requires a diverse range of interpreting and clinical skills and areas of knowledge. Because it can be quite stressful at times, it is also essential that refugee mental health interpreters have an adequate support system and that they receive consistent support from experienced staff within their agency. We examine these points in the following section.

The Hiring, Training, and Ongoing Support of Interpreters (and Therapists)

Hiring. Refugee mental health interpreters should possess many of the same core qualities as those possessed by effective therapists. These include a high degree of empathy, good interpersonal skills, and a high level of psychological mindedness. In addition, our data suggest that because many interpreters who are refugees themselves have their own history of trauma and loss, it is imperative that a reasonable degree of psychological healing has occurred before they start work as an interpreter. Just as unresolved trauma or grief can unexpectedly arise among therapists and adversely affect their clinical work, so can interpreters' own unresolved war- and exile-related experiences interfere with their work in substantial ways. Conversely, our data also suggest that refugees who have done a good deal of their own healing can be highly effective as interpreters, interacting with clients in a sensitive and compassionate way. Finally, given the stressful nature of the work, it is important that anyone preparing to interpret in psychotherapy with refugees have a strong social support network. It is simply too difficult to manage the challenges of interpreting in a context of social isolation and low social support.

Regarding the question of whether it is preferable to hire refugees or people from the host society to work as interpreters, we strongly recommend the former. Despite the potential risks of clinical work eliciting unresolved trauma and grief, we believe the benefits far outweigh the risks. Refugee interpreters, by virtue of sharing the client's cultural and experiential background, are able to serve as therapy conduit, cultural liaison, and initial point of contact and trust in ways that host society interpreters simply cannot. With careful screening, proper training, and good support, many of the problems we have illustrated in this article should be readily preventable.

Training. To our surprise, of the 15 interpreters we interviewed, only 3 had received any sort of training in mental health interpreting. We asked participants to identify the most important topics that should be covered in a training program for interpreters in refugee mental health settings. There was considerable agreement among interpreters and therapists; therefore, we have combined their responses into a single list that includes the following topics: (a) the theory and methods of common psychotherapy approaches, (b) treatment strategies for trauma and traumatic grief, (c) the etiology and phenomenology of mental health problems common among refugees and refugee families, (d) the nature of complex emotional reactions in the therapeutic triad and constructive ways of dealing with such reactions, (e) exposure to a range of interpreting techniques, and (f) strategies of self-care to minimize the negative effects of interpreting painful stories of trauma and loss.

Our data also suggest that *therapists* should receive training on how to work effectively with interpreters. This point has received little consideration in the clinical literature; however, it is evident from our findings that working with interpreters can be challenging and that some training might help prevent certain "bumps" from arising. Specific points we recommend as the focus of such a training include (a) the merits and limitations of the relational and "black box" models of interpreting; (b) the importance of allowing the client's attachment to the therapist to evolve gradually, recognizing that an attachment to the interpreter often develops first and only later expands to include the therapist; (c) allowing interpreters to use either the first or the third person when they interpret (several interpreters noted that the use of the first person can bring the client's experience uncomfortably close to home); (d) providing regular debriefing meetings with interpreters, with the goal of helping them process any distressing clinical material and hearing their thoughts about session material; and (e) explaining to interpreters the nature and purpose of highly specific therapy techniques before their use in session (e.g., hypnosis, eye movement desensitization and reprocessing, progressive muscle

relaxation) to avoid confusion and enhance interpreter effectiveness.

Ongoing support. All of the interpreters we interviewed agreed that supportive debriefing meetings with therapists would be, or actually had been, useful in helping them manage distressing clinical material. Several interpreters met regularly with therapists for this purpose, and they all valued the experience highly. For their part, therapists varied widely in the support they provided to the interpreters with whom they worked. Some therapists added time to the end of each session to meet privately with the interpreter; the majority, however, rarely offered supportive supervision or debriefing opportunities to the interpreters with whom they worked. Most commonly, this was due to a lack of time among busy therapists, all of whom were quick to acknowledge the value of providing such opportunities for support to interpreting staff.

Given the extent to which therapist support was highly valued by those interpreters who received it, we recommend that agencies prioritize the provision of support to interpreters by providing therapists with time to meet with interpreters, individually or in groups, on a consistent basis. Although it remains an empirical question whether such support may prevent interpreter burnout or minimize work-related distress among interpreters, the available evidence seems to support a shift toward the provision of greater institutional support for the difficult work that interpreters do.

Discussion

The findings of this exploratory study generally lend support to the observations of clinicians who have written about their experience working with interpreters in psychotherapy with refugees. For example, several therapists have written about the merits and limitations of the black box and relational models of interpreting (van der Veer, 1998; Westermeyer, 1990), a salient theme in the present study. Consistent with clinical recommendations that generally favor the relational model, our data suggest that the black box model was perceived as inappropriate by the majority of respondents. This is because it failed to recognize the multiple roles played by interpreters as well as the meaningful relationships that develop between clients and interpreters.

Our findings are also consistent with clinical observations regarding the importance of attending to complex emotional reactions that can arise within the therapeutic triad and that can potentially have an adverse impact on the therapeutic process. Although the clinical literature has emphasized the psychological vulnerability of interpreters who are refugees themselves (e.g., D. Kinzie, 1986), our findings suggest that careful screening, adequate training, and ongoing support may minimize the frequency and intensity of problematic reactions among interpreters. It is important to note that there was a near consensus among participants that any increase in distress related to the work of interpreting was generally short lived and exerted a minimal impact on interpreters' overall emotional well-being. In light of the invaluable roles that refugee interpreters are uniquely well suited to play (e.g., cultural liaison, therapy conduit), and given the lack of evidence of any significant adverse effects on interpreters' well-being, we suggest that using refugees as interpreters is not only appropriate but advantageous.

We also found that clinicians may experience a variety of unexpected emotional reactions to the dynamics of the therapy triad, such as feeling excluded from the intimacy of the interpreter–client relationship during the early phase of the therapy, feeling self-conscious at having a third person present in session, and feeling frustrated at what may be perceived as inappropriate interpreter behaviors. Although such reactions appear to be common and are quite understandable, it may be useful for clinicians to consider how they might react to challenging triadic dynamics before actually beginning their work with interpreters. Indeed, the relative frequency of these reactions suggests that they would be a valuable set of foci for a training program designed to assist therapists who will be working with interpreters in refugee mental health settings.

With regard to the hiring of interpreters, our findings suggest that the characteristics that should be emphasized are similar to those possessed by effective psychotherapists. Beyond the obvious requirement that prospective interpreters be adequately bilingual, they should possess a high degree of empathy and self-awareness, they should have done considerable work toward resolving their own experiences of war-related trauma and loss, they should have an adequate support system, and they should appreciate the value of psychotherapy as an approach to healing.

There was a consensus among our respondents, few of whom had received any formal training in mental health interpreting, that interpreters should be trained with a model specific to interpreting in a psychotherapy setting prior to starting work with clients. Participants were quick to offer numerous topics they believed should form the focus of an

interpreter training program, such as the nature of common refugee mental health problems, the theory and methods of psychotherapy, strategies for self-care, and ways of recognizing and managing emotional reactions as they arise in session. Our findings also underscore the importance of providing ongoing institutional support to interpreters. This can be accomplished by building in time for therapists to meet regularly with interpreters to help them process their reactions to difficult clinical material, something highly valued by the minority of interpreters who had access to it.

This study is limited by the small size of the therapist and interpreter samples and by the nonrandomized manner in which participants were recruited. Given the exploratory nature of the study, however, we regard the sample size as adequate to achieve the aims of the study, which were to explore several variables identified in the clinical literature on working with interpreters and to identify other salient variables not previously discussed in the literature. Of greater concern is the geographically limited range of ethnic and national backgrounds among the interpreters in this study. Although this limited diversity does not invalidate the findings of the study, it does suggest caution in generalizing our findings to the experience of interpreters from regions of the world other than those included in this study.

In any study, it is difficult to know with certainty whether one has gathered data that accurately reflect participants' actual beliefs, feelings, and experiences (K. Miller, 2004). In the present study, participants in both groups expressed a high degree of motivation to participate in the project, though for different reasons. Therapists, on the one hand, expressed a desire to see research data gathered that could inform the development of an empirically based approach to training interpreters. Interpreters, on the other hand, expressed a desire to have their perspectives be heard and documented, as a way of countering the historical inattention to their voices within their own agencies and in the clinical literature on psychotherapy with refugees. We regard our participants' enthusiasm regarding the project, together with the very personal nature of the stories they shared with us, as lending support to a view of the data presented here as an authentic representation of participants' actual thoughts, feelings, and experiences.

Future research can build on the exploratory findings generated in this study. For example, it would be useful to assess the relationship of specific process variables unique to the triadic relationship to particular therapy outcomes. It would also be helpful to examine whether the provision of supportive supervision to interpreters actually enhances the quality of their work or their perceived degree of job satisfaction. The data presented here may also inform the development of new measures that assess the core variables identified in this study. For example, a measure assessing core areas of interpreter knowledge, attitudes, and skills would be highly valuable in evaluating the effectiveness of an interpreter training program. On that point, we hope that the results of this study will spur interest in the development of empirically based interpreter training programs. We believe that adequate training can minimize many of the problematic situations identified by participants in this study and is likely to enhance the triadic therapy experience for each of its members.

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