

Dublin Business School

LOST IN TRANSLATION

***“A Qualitative Study of Therapists Experience in
Counselling Cross Cultural Clients and the Need for an
Interpreter”***

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ABSTRACT

With the ever rising cultural diversity within Ireland over the past twenty to thirty years, there also comes a great need for knowledge within cross cultural therapy, such as language, how we speak and express ourselves. Most of the literature in cross cultural psychotherapy comes under different umbrellas such as mental health and vicarious trauma. This purpose of this study was to explore the therapist's experience of counselling clients whose first language is not English and needing the use of an interpreter. It also examined any challenges and barriers that emerged from this. A qualitative approach using semi structured interviews was used to gather information. Four psychotherapists working in different practice centres and having experience working with interpreters within Dublin participated in this study. Three key themes emerged: the role the interpreter adopted cultural differences and the therapeutic relationship. Further issues that emerged were language barriers, miscommunication, vicarious therapist, boundaries and the qualifications and training of the interpreters. Two therapists reported having an interpreter in the therapy room worked to a certain point but slowed down the process and two reported that it just did not work but recognised that it is a necessity when the client does not have enough English. The interpreters qualifications and training were questioned and the need for additional training when working in the therapeutic space. It was acknowledged that interpreters do not have training like the therapist but there is a need for interpreters to have supervision especially when working with traumatic events.

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Chapter 1: Introduction

The purpose of this study is to gain an understanding of the psychotherapist's experience of the therapeutic relationship between therapist, client and interpreter. This study will first examine the differences in culture, conversation etiquette between cultures and of the challenge that language barriers contribute within the therapeutic setting from the perspective of psychotherapists in Ireland.

With an increasing emphasis on culturally relevant treatment, the accepted role of interpretation has expanded from a 'black box', strictly word for word translation model to that of a cultural broker" (Oquendo, 1996; Tribe & Tunariu, 2009; Santiago-Rivera, 1995; Westermeyer, 1990). A cultural broker aids in communication and cultural information and improves the understanding between two people. This is essential in mental health treatment as language is combined with affect and understanding (Marcos, 1979). There have been studies conducted that show in some cases training for interpreters may be inadequate in terms of the demands of the job (Engstrom, Roth, & Hollis, 2010; Raval & Smith, 2003; Yakushko, 2010).

When therapists and interpreters work as a collective and have a trusting relationship, it makes for a better setting in therapy. A qualitative study by Miller, Martell, Pazdirek, Caruth and Lopez (2005) stated that when an interpreter was added into the therapy session it created a triadic therapeutic alliance. These therapists stated when it worked it improved the therapy and the client outcomes. When there are unintended cultural differences between the therapist and client these can interfere with the therapeutic alliance (Miller *et al* 2005). For therapists and interpreters this can be especially relevant. Unintended biases can affect the relationship between the therapist and the interpreter and in turn affect the counselling experience. There are also other differences at play here, therapists can be seen as the experts with more pay and higher education and interpreters are can be viewed as secondary and substitutes (Kaufert & Putsch, 1997). Therapist and interpreters need to work together before, during and after the therapy to establish the working alliance and process the emotional impact on both. Interpreters need to recognise boundaries between themselves and clients.

The literature review sets out to explore previously researched concepts associated with the impact of having an interpreter in the room whilst working with a non-English speaking person. There seems to be a lack of research done on language and the use of an interpreter and what unfolds in the therapeutic setting. This study using qualitative research aims to build theory to those individuals who have personal experiences with working with groups of non English speaking individuals and have personal experiences of working with interpreters. Data will be collected through the experiential sharing of the therapeutic setting. Thematic analysis will be utilized in order to identify, analyse and report on themes within data (Braun & Clarke 2006). Further themes or patterns may emerge from this data which will be identified accordingly. An inductive approach will be used in order to clarify themes or patterns linked to the data (Braun & Clarke 2006).

Chapter 2: Literature Review

2.1 Introduction

This chapter will examine previously researched concepts associated with the impact from the psychotherapist's perspective, of having an interpreter in the room where the client does not speak the same language. This research will look at the therapeutic relationship along with transference and countertransference followed by boundaries and confidentiality. In addition this will focus on the vicarious trauma/therapist, language and translation and how they manifest within the clinical setting, but first this thesis will explore cultures and their differences.

2.2 Cultural Differences

There has been very little consistency by cultural theorists of what culture means (Halton, 1992), although there is a common agreement that culture is a process that is not fixed but continuously moving in time and space within a given society (Eleftheriadou, 1994). Culture is defined as things that people have learned to do, value and enjoy. These are the ideals, beliefs, skills, tools, customs and institutions into which each member of society is born. There has been so many different cultures over the last twenty to thirty years coming into Ireland where English is not their first language (CSO). Some have come from countries of war, torture, witnessing murder, natural disasters or simply by their own choice, because of this there is an essential need to have an interpreter within the therapy room. With this comes the basic need for knowledge of that culture. Knowing a person's culture, how they dress, their religion, how they speak, if they use any particular slang within their language is of great need for both therapist and interpreter within the therapy room (DeCourcy & McCarthy 2003).

Facial and body expressions are often very different and can mean something else within other cultures. They can also be difficult to read. For instance, a Muslim who wears a niqab may not move their eyes much and the therapist will not be able to see their client's facial expressions (DeCourcy & McCarthy 2003). Within therapy it is

important that neither client nor therapist assume certain words, explanations or phrases are understood in the same way, as these can mean different things in different cultures (DeCourcy & McCarthy 2003). For instance some far eastern countries have no separate word for boy or girl they simply use the word child. In other cultures the words, yes and no do not exist (DeCourcy & McCarthy 2003).

According to Patterson (1978) different cultures can have opposite meanings in regard to non-verbal behaviours. Studies of non-verbal behaviour show how they affect perceptions of others (Spinelli, 2005). For example personal space, gestures and eye contact can mean something completely different in another culture. Patterson (1978) states in Japan it is not permitted for a female to make eye contact with a male. Sue and Sue (1977) state that eye contact is used to diagnose within mental health and state there are different meanings for eye contact. Within Middle Eastern cultures, mainly Muslims, they have strict rules regarding eye contact between men and women and are connected to religious laws about appropriateness. They are only allowed a brief moment of eye contact, if that at all. In many Latin American, Asian and African cultures, prolonged eye contact may be mistaken as an insult or challenging behaviour. It is said to be more polite to have limited eye contact, especially when social groups differ, such as older relatives and child or teacher and student. For example if a Japanese woman does not look someone in the eyes, this is not a sign of lacking in interest or of lacking in self confidence but of being respectful and polite within her culture (Scudder, 2014).

Within Africa, Latin America and Indonesia the norm is for clients and therapists to sit close together, which for Western therapists it may not be comfortable (Sue & Sue, 1977). This could be seen as aggressive or intrusive. In Asia silence is seen as a mark of respect and politeness for elders instead of being seen as a desire not to speak (Sue & Sue, 1977). When considering implications in counselling clients from different cultural backgrounds and culture on verbal and non-verbal communications, the therapist must take into account the interaction of language (Sue & Sue, 1977). Having touched on culture this thesis will now examine aspects of language and translation.

2.3 Language and Translation

There has been little information in the literature on the experience of therapists when working with cross cultural clients who do not speak English. According to Healy, Lyons, O'Malley and Antonijevii (2009) Ireland has only in recent decades been a bilingual country. Ireland has become a country of large culture and linguistic diversity. Many overseas clients have little or no English, some may have learnt through television or the internet and others may have been taught by a teacher with a heavy accent (DeCourcy & McCarthy 2003).

Verbal and non-verbal communication is of great importance. According to Javier (1995) language is not the central focus to psychological training but as clinicians it is very relevant, which is vital and intricate to talking therapy. Clauss (1998) talks about language as the unspoken variable and that culture and language create a deeper understanding of human experiences and how they perceive their world. Language is used to form a space whereby clinicians can respond, relate and analyse verbal communication that individuals reveal (Javier, 1995). This helps the psychotherapist to understand their clients (Henley, 1995).

Foster (1995) suggests clinicians respond through their own understanding constructed by individual experiences which can become a barrier in cross cultural counselling. There are often the same words in different languages but have different meanings (Weiss, 2004). The individual will be infused with feelings and connectedness to these words from their language. If the therapist does not have the same language then the meanings can get lost (Weiss, 2004). Carl Rogers (1961) talks about communication failure within psychotherapy, when a person who is emotionally distressed and finds it hard to communicate. As a result communication breaks down and becomes damaged when communicating with others. Having touched on language and translation this thesis will now go into the felt sense.

2.4 Vicarious Trauma/Therapist

Sexton (1999) and Pearlman and Saakvitne (1995) state that when there is exposure to distressing material in regards to trauma there is a risk of vicarious traumatization.

Interpreters in the therapeutic setting need to have a solid background in training especially in mental health issues. This is therapeutically essential and without this, interpreters can actually do more harm than good (DeAngelis 2010, p.52). Such as, “censor psychotic, profane or sexual content out of fear, embarrassment or a desire to “protect” the client” or the therapist (DeAngelis 2010, p.52). They may also give their own interpretation of what the client means and/or discuss therapy sessions with outsiders. They may edit or leave out vital information about traumatic events and feelings because they may have been through something similar and are possibly being triggered and as a result the therapist is not getting all the information (DeAngelis 2010, p.52).

According to Raval (2003) interpreters frequently fulfil numerous roles, including that of a cultural broker. In doing so they are providing a cultural understanding to the therapist and the client, client advocate and bilingual worker. For some interpreters sharing an experience of trauma, culture or history with clients may increase their skills within these roles. However this may also increase the emotional impact within the work (Miller, Martell, Pazdirek, Caruth, & Lopez, 2005). The role of the interpreter is complex and research has largely concentrated on the complexities and the lack of training rather than the emotional impact of working with trauma survivors on interpreters (Tribe & Raval, 2003: Raval & Smith, 2003). Although there is a lack in literature, there is some to suggest interpreters may experience negative and positive emotions within trauma work. This is not just within therapy, fire-fighters and ambulance workers may also experience distress while working with trauma survivors (Brown, Mulhern, & Joseph, 2002: Clohessy & Ehlers, 1999).

Vicarious trauma (VT) is said to stem from an increased and emphatic engagement with another person’s traumatic experience. It is assumed that in long term it can change the way a person experiences themselves, others and the world and may incorporate the clients’ experiences or symptoms as their own (McCann & Pearlman 1990: Pearlman & Saakvitne, 1995). There are acknowledgements that although it can be distressing some people have experienced positive changes as a direct result of experiencing trauma. It is said to have led to enhanced psychological functioning beyond pre-trauma levels (Joseph & Linley, 2005: Tedeschi & Calhoun, 1995). As a result of the positive changes of working with trauma survivors one might assume that

not only the client but those working with the client will experience vicarious post-traumatic growth (VPTG). An investigation into therapists and trauma work (Arnold, Calhoun, Tedeschi, & Cann, 2005) showed participants reported experiences of growth similar to those described by direct trauma survivors (Tedeschi & Calhoun, 1995). There is currently more research on VT than that of VPTG. This was hypothesized within Constructivist Self-Development Theory (CSDT; McCann & Pearlman, 1990). The framework of Constructivist Self-Development Theory (CSDT) combines self-psychology, social cognition and object relations theories. It is built upon a constructivist view of trauma in which the person's individual history forms his/her experience of traumatic events and defines the adaptation to trauma (McCann & Pearlman, 1992).

VT is when an individual is working with a person who has experienced high levels of trauma and is frequently exposed to trauma that challenges fundamental schemas that are connected to psychological needs, such as safety, trust, power and control in which people operate and understand their world (Janoff-Bulman, 1992). According to the American Counselling Association (ACA, 2011) vicarious trauma is "the emotional residue of exposure that counsellors have from working with people as they are hearing their trauma stories and become witnesses to the pain, fear, and terror that trauma survivors have endured". These definitions refer specifically to therapists; recently the focus of VC research has expanded to include members of various professions, such as social workers, humanitarian workers, crisis counsellors, nurses and interpreters (Bontempo & Malcolm, 2012). Figley (1999) states individuals who experience vicarious trauma can display symptoms similar to individuals suffering from post-traumatic stress disorder. The ACA (2011) provides a list of more comprehensive symptoms, such as, worrying about work capabilities, intrusive thoughts relating to clients, hopelessness, reduced satisfaction and not enjoying things as they used to. According to the ACA as a result of these symptoms, professional's behaviours and performances may be impacted as they may start to suffer from increased errors, frequent job changes, exhaustion, low motivation and irritability. As the addition of interpreting has only recently been added to this body of research, exploration of this specific field is limited. Dean and Pollard (2001) state interpreting shows some occupational stresses suffered by interpreters and indicates the interpreters vulnerability to stress-related illnesses, consequently demonstrating the

need for a deeper investigation into the field of vicarious trauma in relation to the role of interpreters.

It has been hypothesized that there are three conditions to facilitate VT in therapists. These include “empathic engagement and exposure to trauma material, empathic engagement and exposure to the reality of human cruelty, and therapist involvement in traumatic re-enactment within the therapy relationship” (McCann & Pearlman (1990), p. 136). However there is little research to say which of these VT conditions are shared with by interpreters and to date there are only two studies which investigated VT within interpreters (Butler, 2008; Harvey, 2001). According to Harvey (2001) the first was a qualitative study on vicarious emotional trauma within sign language interpreters who work with deaf clients. The interpreters stated they experienced “emphatic injury” as they identified with the pain and grief of the clients and of not being able to help remove the pain led them to self victimization and feeling inadequate and having feelings of guilt that were associated to the interpreter becoming aware of their own privileged majority status. A second qualitative study by (Butler, 2008) of the experiences of women interpreters working with wartime sexual violence survivors was carried out. It stated how the participants found it difficult to cope with the emotional side of the work. This was a result of over identifying with the clients story and interpreters were left feeling distressed and overwhelmed. Although there has been a little research done on negative experiences of interpreters working with trauma survivors, there seems to be an absence of research to positive or VPTG experiences in interpreters (Linley & Joseph, 2004).

It is a common misrepresentation that being fluent in more than one language is all that is needed to be an interpreter (Hamerdinger & Karlin, 2003). The role of the interpreter calls for a far more sophisticated and complex set of skills than mere language ability. Effective performance as an interpreter requires knowledge of specialist terminology, an ability to reflect on meaning, memory skills, and knowledge of issues of confidentiality (Tribe and Morrissey, 2004). Many interpreters working in Ireland in public services lack the qualification in translation and interpreting. The interpreters are very seldom tested or trained. According to the Irish Department of Health there is a lack of policy regarding interpreting (Phelan, 2001, p. 2). The interpreters involved in mental health interpreting often speak

English and another language, but they are not trained or accredited interpreters (Zimanyi, n.d., p. 6). The only academic programme available in interpreting in Ireland is run by Dublin City University. There is an interpreting module under the MA in Translation Studies and the Graduate Certificate in Community Interpreting (NCCRI, 2008, p. 17). As cited in Lago (2011, p. 88) “a clinician must also take into account that they owe a duty of care towards the interpreter, whether or not they are employed by an outside agency” (Tribe and Thompson, 2008). Lago (2011) stated interpreters do not have the same training as therapists and may not have access to a supervisor like a therapist would.

2.5 Therapeutic Relationship

According to Miller, Martell, Pazdirek, Caruth, and Lopez (2005) clients experience interpreters as a human presence and engage with them as such within therapy. According to Miller *et al.* (2005) “although some therapists may prefer that interpreters aim for a kind of invisibility, it is evident that clients regard interpreters as anything but invisible. Clients can often have strong emotional reactions to interpreters”. Several therapists have reported that the interpreter can aid as a positive attachment figure and in addition be a supportive presence for clients (Miller *et al.*, 2005; Searight & Searight, 2009; Tribe & Thompson, 2009). Clients may also experience interpreters as important witnesses to their anguish and development and the healing capacity can be increased by the presence of the interpreter (Miller *et al.*, 2005; Searight & Searight, 2009; Tribe & Thompson, 2009; Tribe & Thompson, 2009).

There is limited research on the relationship between the interpreter and therapist. Two studies were carried out to shed some light within this area. The study on therapists experiences working with interpreters, stated all therapists it difficult to create a positive working relationship with interpreters; and as a result of this it affected their ability to build alliances with their clients (Raval & Smith, 2003). Brisset *et al.* (2013) found that power struggles and similar role conflicts affected the development of the interpreter/therapist trust. Hamerdinger and Karlin (2003) state successful merging of interpreters into therapy sessions needs the alliance between the

interpreter and the therapist to be strong. According to Hamerdinger and Karlin (2003, p. 4 -5), “therapists and interpreters need to view themselves as a seamless team ... it is critical that the [primary] alliance be between the interpreter and the clinician,” rather than between either of the providers and the patient. Tribe and Thompson (2009a) promote for “building a fixed alliance in advance” between therapist and interpreter, so that “the clinician and the interpreter are slightly closer to one another than they are to the client, and can share their observations of the work and support one another” (Tribe & Thompson 2009, p. 19). They propose that joint supervision for interpreter and therapist may help with splitting and nurturing cohesion.

2.5.1 Transference / Countertransference

Counter transference is defined as all the thoughts, feelings and activations experienced by the therapist in response to the client (Goldstein & Goldberg 2004). Counter transference was a term originally coined by Freud in 1910 as "a phenomenon that arises in the physician as a result of the patients influence on his unconscious feelings". Freud believed this to be negative to the work and signified that the analyst themselves needed further analysis (Goldstein & Goldberg 2004). Fenichel professed in 1941, as cited in (Goldstein & Goldberg 2004), that therapist counter transference is "making use of the patient for some piece of acting out" in response to the therapists own unconscious needs and inner conflicts and perhaps linked to gender, age and cultural biases held by the therapist (Goldstein & Goldberg 2004). Balint and Balint (1939) pointed out, as cited in (Goldstein & Goldberg 2004), that although the therapist believes themselves to be a blank screen; they may in practice be far from it, with areas like their affective responses, dress sense, contracting and fee being influenced subconsciously.

Winnicott on the other hand pointed out that Counter transference was inevitable observing the therapists basic human tendency to feel both love hate and other emotions in relation to the client but that this could be used as useful data (Goldstein & Goldberg 2004). Heimann (1950) stated, as cited in (Goldstein & Goldberg 2004), that the therapist’s reaction could be the first useful clue as to what is going on for the

patient. Freud changed his view on Counter transference and in his 1912a paper talks about "the remarkable fact that one persons' unconscious can communicate with another". He advised analysts to have "free floating attention" in the session to notice both the patient's words and behaviour along with their own thoughts, feelings and associations in response to this, influenced subconsciously (Goldstein & Goldberg 2004).

2.5.2 Boundaries and Confidentiality

There is a need to establish ground rules and training when working together for both interpreter and therapist, so that therapy can work as well as it can. Many training bodies are adding training in working with interpreters as part of their required curriculum (Royal College of Psychiatrists, British Psychological Society). In addition issues of support and supervision for interpreters need some thought. While issues of trust, a clear distinction of boundaries around confidentiality and the limits of information need to be discussed in full before the client turns up for therapy, as this could compromise the therapeutic work if not done (Tribe & Keefe 2009, p. 418 - 420). A case study cited in Lago (2011) by Salihovic (2008) on interpreters and therapists working with survivors of traumatic events discovered that therapist's greater empathic ability was related only to the therapists as greater compassion fatigue. The compassionate fatigue for the interpreters when exposed with traumatic events resulted in low levels of social support. From this it is deemed necessary for interpreters to have ongoing supervision and support (Lago, 2011).

2.6 Conclusion

This chapter has discussed the therapeutic relationship, which also involved transference and countertransference and from there the boundaries and confidentiality of interpreters within the therapy room. This chapter went on to explore vicarious emotion, vicarious empathy and the vicarious therapist. In addition it looked at language and translation and how they manifest within the clinical setting and from there explored cross cultural differences.

Chapter 3: Methodology

3.1 Introduction

Having explained culture and their differences, language and translation, vicarious trauma/therapist, the therapeutic relationship along with transference and countertransference and boundaries and confidentiality within in Ireland this next chapter will introduce the method chosen for the research, the participants in the study, how they were recruited, the data collection process, the data analysis and any ethical considerations pertaining to the research.

3.2 Aims

The purpose of this study is to explore what emerges within the therapeutic space from perspective of the psychotherapist's when clients whose first language is not English and need an interpreter in the room. Furthermore this will examine differences cultural behaviour such as eye contact. This will then go on to discuss any barriers that may emerge with language and communication. The main purpose is to explore the therapeutic relationship between, therapist, client and interpreter and any challenges that may evolve within the therapeutic space.

3.3 Research Design

A qualitative research using semi-structured interviews was selected for the study. A qualitative research interview according to McLeod (2003) is a dialogue where the research is of interest to both interviewer and participants. One disadvantage was that the informant may be influenced by the interviewer when it is a one to one interview, but in this case there was a real curiosity to understand the participants experience and views for this research (McLeod, 2003). This was done to get an exploration from the perspective of the therapist on their own personal experiences of working with interpreters in the therapeutic space and to explore what emerged from this. So a qualitative research seemed more appropriate to explore the impact this had on the therapist and their work. A qualitative research is a form of social analysis that

focuses' on the way people construe and decipher their experiences and the world in which they live (Bryman, 2008, p. 22). This is not just about statistics but real people and real experiences (Gillham, 2005, p. 8). This semi-structured interview allowed for flexibility within the interviewing process, it offered details of 'what the interviewee views as important in explaining and understanding events, patterns, and forms of behaviour' (Bryman, 2008, p. 438).

3.4 Participants

The participants were based on psychotherapists having worked with clients whose first language was not English and also needing the use of an interpreter within the therapeutic space. At first the criteria for this was at least two years consecutive experience but this was deemed harder than anticipated. It was difficult to find participants. The use of the IACP website turned out to be another option, whereby another participant was found and agreed to take part in this research. Initial contact was made by phone which followed by an email (see Appendix 5) outlining what the research was.

The sample consists of four psychotherapists, two male and two female all of whom have experience working with cross cultural clients whose first language is not English and need the use of an interpreter within therapy sessions. The participants were chosen specifically because they have experience working with interpreters within therapy sessions. It was felt that they could contribute to the research not because of what they specialized in but because of their knowledge and experience of working with interpreters on a regular basis. Each participant filled out a demographic information sheet so the researcher could get an idea of what type of experience they had (see Appendix 3).

3.5 Data Collection

The participants were interviewed at a convenient time and place. Two of the participants were interviewed at the work place and two were interviewed over the phone. The interview venues were chosen by the participants for their own

convenience. Due to time constraint and place of work address it was convenient for the other two participants to have over the phone interviews. The title and purpose of the research was explained to all, as well as having the right to withdraw from the research and have access to and edit their transcripts at any time. A consent form and a demographic form was emailed to three participants and handed to one participant (see Appendix 1 and Appendix 2). The consent form was read and signed by all participants within this research. The interviews were recorded using a digital voice recorder, and the sound files were safely stored to be used for the transcription and data analysis process at a later stage. The interviews were transcribed and typed verbatim by the researcher and thoroughly read to establish “a feel for the content” (Gillam, 2005, p. 125).

A semi structured interview was deemed most appropriate with twelve open ended questions, which was informed by the literature review plus some extra questions were asked within individual interviews (see Appendix 4). The questions were reviewed by the researcher's supervisors, feedback was given and amendments were made following recommendations. It felt that the open questions would allow for the participants to give a more accurate account of their experience and also allowed for the participants to introduce any other important issues or topics. From each interview the experience and information that was gathered led to several questions being added pertaining to the individual participants (see Appendix 4). The interviews were no more than thirty minutes long.

3.6 Data Analysis

The data collected from the semi structured interviews was analysed using thematic analysis. This was used to identify the participant's experiences of having an interpreter within the therapeutic space when English is not the first language of their clients. The transcripts were read and different themes emerged from this reading. These themes attempt to explain the concepts illustrated and structure of the data retrieved from the participants (Schacter, Gilbert & Wegner 2012, p. 72). Analysis of this qualitative research will allow a more informative evaluation from the perspective of the participants on whether having an interpreter within the therapeutic room is

useful or not useful and the experiences that emerged from this (Schacter, Gilbert & Wegner 2012, p. 72). Further reading of the transcripts ensued, in the search for additional information and to make sure those themes reflected the participant's true experiences of working with cross cultural clients with the need of an interpreter.

3.7 Ethical Considerations

Ethics in qualitative research includes different ethical considerations that may affect the outcome of the study. Prior to conducting the research, it was approved by the DBS research ethics board. Belmont (1979) points out three principles: respect for persons/autonomy, beneficence/non-maleficence, and justice. These principles were addressed in this study. In relation to the researcher/participant relationship, the sample consisted of psychotherapist who agreed to give an account of their experiences with interpreters. This group was not classed as a vulnerable group therefore this minimized possible harm and beneficence. The researcher acquired signed consent forms from the participants in the study (Appendix 1). This principle adheres to the issue of “respect for persons and protecting the autonomy of all people and treating them with courtesy and respect and allowing for informed consent” (Belmont). The participants were aware that the participation in the research study was voluntary and they had the right to withdraw from the study at any stage. Anonymity was provided by the researcher by using pseudonyms. Furthermore identifying data, recordings and transcripts were kept secure during this research.

3.8 Conclusion

This qualitative study aims at exploring the impact on psychotherapists working with interpreters when cross cultural clients first language is not English. Semi structured interviews were used to collect information and thematic analysis was considered the most appropriate method for analysing the data. Ethical considerations were also examined. The next chapter will give voice to the psychotherapists who participated in this research study.

Chapter 4: Results

4.1 Introduction

This chapter will examine and report on the participant's experience and clinical perspective along with their narratives. The aim of this research was to explore any challenges and barriers from the psychotherapist's perspective of cross cultural clients whose first language is not English and require the use of an interpreter. Three themes emerged from the semi structured interviews which have resulted in three topics for analysis. There themes are:

1. The Role Interpreter the Adopted
2. Cultural Differences
3. Therapeutic Relationship

4.2 The Role the Interpreter Adopted

Three of the therapists reported that the interpreter may have been intrusive in the therapy room. Ben stated: Sometimes they are un-boundaried and they might ... take on too much ... try and give the client advice ... which is unwelcome. While Paul explained:

The client will turn to the interpreter and use the eye contact and direct all of their body language towards them ... to me somewhat as well. The interpreter plays an important role in ... the transference part of the therapy ... the interpreter will have his own values, beliefs preconceptions and sometimes they will come into the therapeutic session as well.

Similarly Isla recalled

In the therapeutic sense the interpreter took the third object, the transitional object. It became a three part dialogue ... a three part dynamic. They became both a barrier and also they provided an extra way to integrate and to discuss and to dialogue but a lot was lost in transition.

In contrast to these views Ava report:

When you have a good interpreter it means that they are almost invisible. They say word for word what the client says as far as possible, taking into account language and culture.

4.2.1 Useful or Not Useful

The participants acknowledged that the presence of the interpreter was essential in the room due to the language barrier. However Ben expressed the notion that the presence of the interpreter was not always useful. He stated:

I would prefer not to have an interpreter most of the time as it slows the therapy down and there is sensitivity that you would be worried for the client. They don't have the same therapeutic boundaries that we would have, in terms of allowing people to make up their own minds.

Isla mentioned that the interpreter could be “used as a block. It aided understanding ... to open up ... to build trust but it was also a block”. Ava stated that they could not manage without an interpreter but added that the work took much longer saying “What you might get done in fifty minutes without an interpreter ... might take three or four sessions. So it is a very slow process”.

On the positive side participants were in agreement that the presence of the interpreter was useful. Isla commented that the interpreter could help put the client at ease and Paul mentioned “the interpreter might be either from the country of origin ... or from a different country, which is beneficial sometimes”.

4.2.2 Vicarious Trauma

When exposed to material that is distressing such as trauma there can be risk of vicarious traumatisation. Some of the therapists have reported that some interpreters may become too emotionally invested with the clients depending on the material

brought in. One reported the interpreter may want to add their own story or feelings to support the client and that this was a good thing. Whilst another reported that interpreters may leave material out because of what is being brought into the therapy room.

Paul: The interpreter might start feeling or having feelings for their client in the sense if the client is going through a very rough time and the interpreter themselves have been in that position before. They can empower the client.

Ava expressed that interpreters are not trained to relay back traumatic events and can be affected by this, she reported, “sometimes because of the content ... severe trauma, the interpreters aren't properly trained for that ... they might be trying to distance themselves from what they are hearing. So they might just summarise... not listen properly ... would be ... embarrassed about what the client is saying. When coming from the same country, certain human rights abuses are happening, they might ... have witnessed or ... have impacted their families ... or ... have family ... going through the same thing. It can be very difficult for the interpreters.

4.2.3 Vicarious Therapist

All the participants agreed that the interpreter's job is to relay word for word where possible what the client has said to the therapist and vice versa to the client. Three of the participants reported that at times the interpreter can nearly become the therapist and they would need to speak with the interpreter before or after the session to address this.

Ava: If it is a bad interpreter it's a very difficult session. Sometimes they take on the role of the therapist themselves, sometimes they are upset by the content so they start to disassociate a little bit or react a bit. They want to separate themselves from what is being said, so they might mock the client in some way with eye gestures or not interpreting correctly. So it ... is a major issue for us.

Whilst Paul reported that this can be a positive for the client and went on to say:

The interpreter is almost like ... the guide of the therapist in ... that the eye contact and body language is turned to the interpreter. The interpreter ... might be quite empowering for a client because ... they might be from their own country and ... the way they demonstrate their body language also speaks a sort of tongue ... the message can get across properly and it can be quite powerful to watch in the sense of you can actually see how two people interact with such active debate and active analysis and even the interpreter don't know they are performing a sort of role because it is unbeknownst to them ... they almost dawn this role of therapist.

4.2.4 Qualifications/Training

There are no regulations in regards to qualifications, interpreting training and working conditions. Interpreting needs of public service users are covered with foreign language speakers who are not necessarily qualified interpreters. Two therapists reported there was a lack of training for interpreters within Ireland.

Ben: When an interpreter comes in ... the lack of professional training in Ireland is ... shocking. They don't have very good personal boundaries or professional boundaries in terms of ... working with clients there is no certification for it.

Ava: Interpreters have different levels of skills in the therapy room because there's no standard that they have to follow in order to work. Our (organisation) is trying to get some kind of standard put in place in regards to training, education and some qualifications.

Two of the therapists went on to say they offer a debriefing to the interpreters either before or after the therapy sessions in case anything came up for them.

Ben: If there is anything upsetting in the session that they can come to me after ... and talk to me about it.

Ava: The therapy clinic will always give them a briefing beforehand to make sure that they are aware of the type of thing they will encounter in the room and ask them if it is still okay to continue and go ahead with the session.

4.3 Cultural Differences

All the therapists reported that there were some culture differences within the therapy room, especially around eye contact.

Paul: I don't think it differs but important to know the culture in relation to how therapy sessions are conducted. In parts of Africa it would be rude to have eye contact ... it would be disrespectful. In other cultures looking in the eyes is very important ... you would be considered ignoring them if you weren't looking them in the eyes.

Whiles Ben reported there are “different power dynamics ... in the therapy”. Further to this he stated his job description gets confused a lot.

Some countries ... psychotherapy is ... unknown. There's confusion of my role and that of a medical doctor.

Whilst Isla stated working with children under eighteen and the difficulties of trying to converse with the parents who don't speak English and went on to say:

Working with their children ... you have to be careful what you feed back to their parents ... in a weird way it is a three way relationship. When dealing with ... under eighteens ... you have to deal with their parents who don't speak English and then you are using the child as an interpreter. It can get very tricky.

4.3.1 Language Barrier/Miscommunication

Three out of the four therapists reported miscommunication happens within therapy when a non English speaking client needs an interpreter. Isla stated: “cultural nuances are going to create a disconnect ... doesn’t work in my experience”. For example:

“I went to college with a girl who had to change her therapist ... she had excellent English ... she needed ... a therapist from her own country ... too much to have to adjust her speech ... that would be understandable by the therapist.

Whilst Paul went on to say:

“Not all languages translate perfectly from English to whatever language you are dealing with. You have a third person who is interpreting that potentially. You sometimes look and think if someone really understands what is being talked about”.

4.3.2 Interpreters Leaving Out Information

Two of the therapists reported that at times through their gut feeling the interpreters may have left out information that the client has given. Paul reported that the interpreter did not explain properly what the client was saying.

There are times where the client might turn to me ... with their broken English ... he’s not explaining properly and I don’t want this interpreter.

Whilst Isla reported that although you may have an idea that the interpreter is not telling you everything but you may never know exactly what.

You don’t know ... the person will say something ... for a minute and a half and then the interpreter says a short sentence or two ... you know that stuff is being lost in the translation.

Furthermore Isla stated when asking the interpreter was anything else said, they replied no.

This person ... is making a judgement on ... important things about that information. When you are in the room with somebody and there is an interpreter ... something of such significance being discussed ... the dialogue between the interpreter and the client has more in it than you will be let know.

Whilst Ave reported interpreter were either not trained well or not at all. All participants were of the same view that interpreters have at times left out information. Ava also reported on the language differences.

Sometimes we have difficulty getting people who speak exact dialogue. There can be ... tiny differences that can make a huge difference in the language.

4.3.3 Difference in working with Interpreters

Two of the therapists reported that there are a lot of differences when working with interpreters as opposed to a one on one therapy session. Ava reported on the differences of working with interpreters when trauma comes into the therapy room.

Ava: Absolutely ... there is always the presence of the third person. With our client group ... there are always issues around trust ... someone who is interpreting could be from their home country. We have to make sure is ... comfortable as possible, as much control as possible in the session. We allow choice of gender, choice of area of interpreter ... always check in interpreter was appropriate ... also check ... interpreter ... they are okay after the session.

However, although Isla reported it is different she also stated it can be a positive.

Isla: It's completely different ... it's like night and day. One on one is ... very different to when it's a three way conversation. It can also be a benefit ... I was working in ... child protection, because there is a witness to it. So there are pros and cons to it.

This therapist further reported other differences such as eye contact which is very important. They reported that when asking anything they need to always look at the client even though the interpreter is the one interpreting back to the client.

Isla: The eye contact is between you and the client and now you are looking at the interpreter, explaining your questions, you have to stop doing that. It's not a natural feeling to not look at the person you are talking to ... you are supposed to be talking to your client.

4.4 Therapeutic Relationship

Upon discussing the therapeutic relationship three therapists reported that when the client and interpreter end up having a rapport with each other that it has a negative effect on the therapy sessions.

Paul: It can and sometimes ... not in a helpful way. When the client has to leave the building ... and the interpreter ... leaves ... also ... they may continue to have a conversation post therapy session. There are times where that might be okay and beneficial ... but very seldom ... because ... you can see the interpreter had developed transference with the client as well as the client for the interpreter ... the client may not want the interpreter to continue the therapy sessions afterwards quite often.

Ben: The interpreter and the client can't have that rapport because it just destroys the therapy. That kind of rapport is developed and can exclude the therapist from doing the work.

Isla: It is not a therapeutic relationship because the interpreter is not a therapist. The first connection ... they will have had a discussion ... in the waiting room. They already have a connection, they understand each other in a way I don't. You're like the third party, not the interpreter.

Whilst Ava reported “this should never happen if done correctly and strict boundaries are put in place”.

4.4.1 Transference / Countertransference

All participants agreed that transference and countertransference was something that came into the room but not just with the client and therapist but also with the interpreter. Two therapists’ reported transference and countertransference as a negative.

Paul: If there’s ever transference between the client and the interpreter more commonly it is negative. It could be ... language not being translated ... interpreted correctly. Client ... might depend on the interpreter solely ... because they have disclosed so much ... they wouldn’t ... use a different interpreter. There will always be a relationship ... a therapeutic relationship between the client and the therapist ... and transference directed to it.

Ben: The client ... might not understand the process of therapy. Sometimes they might see the organisation ... just another branch of governments ... they may have come from a place where any government officials ... be very cruel ... and violent to them. So the client ends up having to size up two people, me and the interpreter a lot of the time.

Whilst Isla reported on the dynamics that emerge within the therapy room not only with the client and therapist, but also the interpreter.

Counter transference with three people ... happens with the three people in the room. Any time two human beings relate or connect ... there is counter transference. There’s between the client ... interpreter ... and therapist. Instead of two people in the room and maybe four dynamics, there are three people ... and six dynamics going on.

4.4.2 Boundaries / Confidentiality

All of the therapists reported that the interpreter at times will continue conversations after the therapy session with the client and has found this to be a negative affect on the therapy.

Paul: Quite often I have to talk to the interpreter ... the important aspect of therapy is that it stays in the room and as soon as the person walks out of the door we all go our separate ways and return again once the therapy session begins the following week..

Ben: We ... had problems with clients and interpreters ... having a chat outside, so we almost separate them before ... and afterwards. We tell them not to have relationships but Ireland is a very small place.

Two of the therapist's further reported clients are fearful of interpreters being spies.

Ben: Clients are fearful of people from their home country knowing their business because they may have been tortured. So they are afraid ... officials or spies from their home country might be the interpreters.

Ava: There have been instances of safety and trust ... the interpreter might actually be a spy and working for their government ... their privy to information that the client is saying ... that can put the client in a lot of danger.

4.5 Conclusion

The therapists interviewed whilst working in psychotherapy with cross cultural clients whose first language is not English, reported that there were major differences working with interpreters than on a one to one basis. There appeared to be a deeper awareness on the complexities of the relationships that emerge within and outside of the therapy room. In addition to this the majority reported that the language barrier and miscommunication slows down the process of therapy. The next chapter will discuss the results of this chapter and will compare the participants experience with the literature reviewed.

Chapter 5: Discussion

5.1 Introduction

The objective of this research project was to explore the challenges and barriers of cross cultural clients whose first language is not English and require the use of an interpreter in the therapeutic room from the perspective of psychotherapists. This chapter will compare previously published literature with the experiences of the therapists who participated in this study leading to formulations of recommendations. The themes that will be engaged with in this chapter are as follows:

- The role the interpreter adopted
- Cultural differences
- Therapeutic relationship

5.2 The Role The Interpreter Adopted

There were some mixed views on what the role of the interpreter was and whether or not the role they took on was beneficial or not. Brisset et al. (2013) state there are power struggles between the interpreter and therapist and this can affect trust between them. One therapist stated they preferred not to use interpreters but acknowledged the necessity for non English speaking clients. According to Hamerdinger and Karlin (2003) the interpreter may be able to ease themselves into the triad within the therapy sessions but only if the interpreter and therapist relationship was able to develop strongly. Tribe and Thompson (2009a) state the therapist and interpreter develop a rapport prior to the therapy session instead of the interpreter and client. This way the interpreter and therapist can support each other. This present research found the majority of the participants felt that interpreters were intrusive in the therapy room, except for one who reported they felt that this can be beneficial but not always. They reported the interpreter will bring in their own core beliefs and values to the therapy room and went on to say the interpreter's role was very important. Another went on to say the interpreters have no boundaries and at times can try to give advice or take on too much. Additionally one participant took on the view that the interpreter was

another way to get an understanding of what was happening within the therapy room. They went on to say it became a three part dynamic and as a result it also became a block to the therapy. One went on to say that without the interpreter the therapy would not be able to carry on especially when the client does not have enough English.

5.2.1 Useful or Not Useful

According to Miller et al. (2005) interpreters can add to the support system for clients in therapy. Rogers (1962) stated when client and therapist do not speak the same language there can be communication failure. All therapists in this study viewed that it is essential for interpreters to be present when a client's first language is not English. However it was expressed that it slows the therapy down so much that what you would get done in one session with an English speaking client could take anywhere up to four sessions with a non English speaking client. One was of the view that the interpreter helped to ease a client and the familiarity of having someone from their home country at times would be beneficial. Another participant went on to say interpreters at times can be used as a block during therapy.

5.2.2 Vicarious Trauma,

According Sexton (1999) and Pearlman and Saakvitne (1995) because of certain material that comes into the therapy room such as trauma that this can affect the interpreters in a negative way. Especially if they or a family member have being through something similar. According to DeAngelis (2010) if the interpreter is not prepared for what comes into the room this can also affect the therapy session and can actually cause more harm. Figley (1999) stated the interpreter can take on feelings that are similar to the client over time. The ACA (2011) said from hearing these traumatic stories that individual's behaviour or performance can change in a negative way whereby they can make mistakes. Two of the participants agreed with this saying the interpreter may, out of embarrassment or being triggered by a traumatic event may brush over what has been said and summarise so as not having to repeat every detail of it. According to Arnold et al. (2005) therapists working with trauma

over time felt a growth similar to the client when in the healing process. The researcher has not found anything to say the same about interpreters. However Miller et al. (2005) stated the interpreter can not only increase their skills but can increase the emotional impact within the therapy room. One participant agreed with this saying it can be a good thing whereby the interpreter can give feedback of what they went through so the client knows they are not alone in their trauma and may encourage the client to open up more.

5.2.3 Vicarious Therapist

Although this is not in the literature review three of the participants went on to say the interpreter at times can take on the role of the therapist. The participants reported clients may direct all their body language and eye contact to the interpreter even when the therapist is speaking. One participant went on to say it can be quite powerful to watch.

5.2.4 Qualifications/Training

The majority of the participants agreed that there is a lack of training or qualifications for interpreters especially when it comes to interpreters working within the therapeutic space. According to Tribe and Thompson (2008) therapists have a duty of care not only to the client but also to the interpreter. One therapist reported that they tell the interpreter that they can speak to them after the session if anything comes up for them. One went on to say that the interpreters are often not told what type of interpreting they will be doing. As a result of this the participant said they would have to explain beforehand what could come into the therapy room and ask the interpreter if they are still okay to interpret for them. They will often debrief them before or after a session to make sure they are okay. The Irish Department of Health state there is a lack of policy regarding interpreting (Phelan, 2001). Zymanyi (2001) stated within mental health interpreting you need only to be able to speak English and another language. One participant went on to say they would prefer when they could not to use interpreters. According to the Royal College of Psychiatrists, British Psychological Society they are trying to implement training whereby the therapists are trained in

how to work with interpreters. As the interpreter is not trained in the same capacity as the therapist there is no supervision that they need to attend. However a study by Salihovic (2008) on interpreters and therapists working in the area of trained stated it is necessary for interpreters to have supervision.

5.3 Cultural Differences

DeCourcy and McCarty (2003) state some differences in culture such as eye contact can have an affect within the therapy room as they can have another meaning. This was something that came up a lot with all of the participants. They all agreed that eye contact can mean different things. The majority said that in some cultures not making eye contact would be seen as rude and in others it is very important. For instance, according to Sue and Sue (1977), within Middle Eastern cultures only sporadic moments of eye contact are permitted. Patterson (1978) states in Japan women are not allowed to make eye contact with men.

Although this is not in the literature review two of the participants reported there are differences in working with interpreters. For instance one participant stated the presence of the interpreter is very prominent in the therapy room and the need to make sure the client is a comfortable as possible greatly comes into this. They also expressed issues around trust with the client for the interpreter. The other participant expressed with the type of counselling they partake in such as child protection that it is the complete opposite of working on a one to one basis. However they did express that having an interpreter in the therapy room can be beneficial as there is a witness to what emerges but that it does have its pros and cons.

5.3.1 Language Barrier/Miscommunication

According to DeCourcy and McCarthy (2003) having knowledge of a person's culture is very important and not to assume explanations or phrases will mean the same thing in other cultures. DeCourcy and McCarthy (2003) also stated that not all words can be translated back into English and also some words in English simply have no meaning in other languages. According to Patterson (1978) certain words in different

cultures may mean the complete opposite in English. Within this theme all but one participant agreed that language is a barrier and miscommunication happens. One participant stated it only differs if the interpreter is from a different country to the client. According to Foster (1995) therapists use their own experiences and understanding to respond to the client and this can become a barrier in therapy. Three of the participants agreed that there can be a lot of misunderstandings and miscommunications with language. Also reporting not all words can be translated into English. These participants also reported that it is translated from therapist to interpreter to client and words can get lost in translation and can create disconnect within therapy. Two of the interpreters stated the interpreter at times is making a judgement on what bits to translate back to the therapist and vital information ends up lost to them. While the literature postulates that language and cultural difference was very important, however the therapists seen this as a barrier. It may be suggested that there is a level of resistance on the part of the therapist, bearing in mind that from the clients point of entry to the country they will have dealt with interpreters.

5.3.2 Interpreters Leaving Out Information

Three of the participants reported interpreters leaving out information with one saying, the client in their broken English said the interpreter had not explained properly. Whilst another participant reported that you may have a feeling that you are not getting all the information but without being able to speak the language you may never know. Similarly one participant reported that interpreters at times make a judgement on what is important and what is not and just summarise what is being said. According to (DeAngelis 2010) if an interpreter is not trained properly or has gone through something similar to the client they may become triggered and/or embarrassed by graphic information and they leave out vital information.

Such as, “censor psychotic, profane or sexual content out of fear, embarrassment or a desire to “protect” the client” or the therapist (DeAngelis 2010, p.52). They may also give their own interpretation of what the client means and/or discuss therapy sessions with outsiders. They may edit or leave out vital information about traumatic events

and feelings because they may have been through something similar and are possibly being triggered and as a result the therapist is not getting all the information (DeAngelis 2010, p.52).

5.3.3 Difference in working with Interpreters

Working with interpreters changes the therapeutic space; it is no longer a one to one but now a triad whereby everyone needs to be comfortable. One of the participants reported differences in working with interpreters in the area of trauma, whereby they needed to look after the client more, making sure they are comfortable with the interpreter. They also reported they had to also check in with the interpreter to make sure they were ok after the session. This coincides with the literature whereby Lago (2011) stated the need for supervision and support for interpreters when interpreting traumatic events. Whilst another participant reported when they are talking they must always keep eye contact with the client even though you are speaking to both client and interpreter. Whilst this is not in the literature it came across as being extremely important.

5.4 Therapeutic Relationship

According to Miller et al. (2005) the interpreter is a human presence in the room and the client will engage with them as such. One participant viewed the client and interpreter rapport as being a positive one that can be beneficial to the therapy but it also has its downfalls. Miller et al (2005) state some therapists prefer the interpreter to be almost invisible but state clients do not agree with this. Although one of the participants reported that when you have a good interpreter then they are almost invisible. Miller et al (2005) goes on to say clients can experience strong emotions towards the interpreters and additionally they can support and aid the client's therapeutic process. The participants went on to say the client and interpreter may converse after therapy and the interpreter at times can develop transference for the client and vice versa with the interpreter. The majority reported when client and interpreter develop such a rapport it ends up having a negative effect on the therapy

process, so much so that the client may request to have another interpreter next time. Two participants went on to say that when this happens the therapist ends up being excluded and it destroys the therapy. According to Raval and Smith (2003) therapists found it difficult to build up good relations with interpreters and in turn this affected the therapeutic space with the client. One participant went on to say the interpreter is no longer the third party, the therapist is. The participants experience does not correspond with the literature from Raval and Smith (2003). Based on the researcher's opinion of the participants discourse, there was a sense that there may also be a level of resistance on the part of the therapist when working with interpreters.

5.4.1 Transference / Countertransference

Goldstein and Goldberg (2004) stated countertransference is all thoughts, feelings and activations experienced by the therapist in response to the client. Now there is a third person in the room and all participants stated that this is not just with therapist and client but also with the interpreter. One participant stated if this happens between client and interpreter it's only ever negative, stating the client has brought in so much that they would not be open to using a different interpreter, if for example the interpreter was sick. Whilst another participant reported whenever people connect there will always be transference and countertransference.

5.4.2 Boundaries / Confidentiality

According to DeAngelis (2010) interpreters may discuss therapy sessions with people outside of this area. There has not been much research to be found on this but one participant did report they do not have the same guidelines to follow as the therapist. At times they try to put in suggestions during therapy and this is not a good thing. The interpreters and clients also often converse with each other before the therapy session and even afterwards. The participant reported that they would have to talk with the interpreter and ask them not to do this but it is not always possible. However two of the participants reported that some interpreters have turned out to be spies from the client's country, although this is not in the literature review. The participants went

on to say that some clients are fearful and afraid and they would fear for their safety because individuals within the government of the client's country have posed as interpreters.

5.5 Conclusion

This chapter has compared previously published literature with the experiences of the therapists who participated in this study. This study shows the use of an interpreter is a necessity. In the researcher's opinion this study shows that not only can the therapist be affected by what presents in the therapy room but also the interpreter. It would also seem that the therapist and interpreter would need to have a conversation beforehand to allow the interpreter knowledge of what their role is and what is and is not expected of them. The literature review in this thesis was sought mostly from outside of Ireland as there was a lack of research in the Irish context.

RECOMMENDATIONS FOR FURTHER RESEARCH

In the researchers opinion from this study it became very apparent that there is a lack of training for interpreters when in the therapeutic space and according to one participant they are most often not told what type of interpreting they will be doing. The researcher also came up against a lot of barriers in lack of training and understanding of this area in Ireland as there was not much Irish literature.

The researcher recommends that counsellor training programmes give more attention to working cross culturally and especially on the subtle cultural nuances in body language and non-verbal communication. The HSE have published a guide on multicultural care needs (Health Services Intercultural Guide) and colleges the researcher would recommend for this to include in their curriculum.

The researcher would recommend the need for interpreters to have a greater understanding on what happens within the therapeutic space and the need to have specific training on this so they are better prepared. Interpreters may not be therapists and have the same training but they listen and repeat everything that goes on in the therapy room and there is a lack aftercare for the interpreter. The researcher would recommend that supervision is a necessity for interpreters as they also can be trigger with what emerges in the therapy room.

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APPENDIX 1: CONSENT FORM

CONSENT FORM

My name is Chiara Antolovi and I am currently undertaking a BA in Counselling and Psychotherapy at Dublin Business School. I am inviting you to take part in my research project which is concerned with exploring the challenges and barriers of working with different cultures that do not have English as their first language and the need of an interpreter in the room. I will be exploring the views of people like yourself, all of whom work with interpreters.

What is Involved?

You are invited to participate in this research along with a number of other people because you have been identified as being suitable, in having experience with working with interpreters within counselling and psychotherapy for at least two years. If you agree to participate in this research, you will be invited to attend an interview with myself in a setting of your convenience, which should take no longer than forty minutes to complete. During this I will ask you a series of questions relating to the research question and your own work. The interview will be recorded and transcribed in written format. After completion of the interview, I may request to contact you by telephone or email if I have any follow-up questions.

Anonymity

All information obtained from you during the research will be anonymous. The transcriptions and other notes about the research and any forms you may fill in will be coded and stored in a safe place. You will be given a pseudonyms name for the purpose of the research and your name will not appear in the transcription or research paper. All data stored will be de-identified. Audio recordings and transcripts will be made of the interview and will be coded by number and kept in a secure location.

Your participation in this research is voluntary. You are free to withdraw at any point of the study without any disadvantage.

DECLARATION

I have read this consent form and have had time to consider whether to take part in this study. I understand that my participation is voluntary (it is my choice) and that I am free to withdraw from the research at any time without disadvantage. I agree to take part in this research.

I understand that, as part of this research project, audio recordings and transcriptions will be made. I understand that my name will not be identified in any use of these records. I am voluntarily agreeing that any audio and transcriptions may be studied by the researcher for use in the research project and used in scientific publications.

Name of Participant (in block letters) _____

Signature

Date / /

APPENDIX 2: DEMOGRAPHIC FORM

Demographic Form

Instructions: Please provide a response for each of the following questions:

1. **What is your age range?** 25-40 40-55 55-70 70+

2. **What is your gender?** Female Male Gender Neutral/Fluid

3. **With what denomination or faith tradition do you most closely identify?**

4. **Please select from the options below the orientation(s) of your core training as a psychotherapist?**

Humanistic Integrative Psychodynamic

Person Centered Psychosynthesis Transpersonal

CBT Psychoanalysis Body Centered

5. **Please select from the options below the modalities used in your practice as a psychotherapist?**

Humanistic Integrative Psychodynamic

Person Centered Psychosynthesis Transpersonal

CBT Psychoanalysis Body Centered

6. Please select from the options below the level of training you have attained to date.

Diploma (QQI Level 7) Bachelor's Degree (QQI Level 7)

BA Honours (QQI Level 8) Masters (QQI Level 9)

PHD/Doctorate (QQI Level 10) Other: _____

7. Please specify the member organizations that you are accredited with:

IACP IAHIP PSI IAPCA ICP

Other(s): _____

8. How long have you been practicing as a psychotherapist? _____

9. How long have you been working with interpreters? _____

10. Are you also an accredited supervisor? Yes No

PRIVACY AND CONFIDENTIALITY

Participants will be provided with information regarding the topic of research, the features of its design, the possible risks and benefits from participation in the research, and their rights as research participants. These rights will include the voluntary nature of the study, their right to choose what to disclose during the semi-structured interviews as well as the right to withdraw from the study. These points will be outlined in a written document which will be provided to participants prior to the completion of the interviews, along with an invitation to raise any queries regarding the research itself or the document. In accordance with Kvaales (2007) guidelines, participants will be briefed in greater detail about the nature of the research, as well as to the purpose and procedure of the interview prior to taking part. Confidentiality for participants will be ensured by protecting their identities. Their identities will be disguised by the use of pseudonyms on all documents, and a list of participants will not be published in the research paper, however can be made available as an appendix to the moderators if necessary. These measures will be carried out in a manner that will not influence the meanings within the data content in any way. Only the researcher will have access to the interview recordings and these will be stored on the researcher's personal computer and secured with a password only known by the researcher.

APPENDIX 3: DEMOGRAPHIC INFORMATION

The table below describes the profiles of each participant that were interviewed during the field research. It also demonstrates their demographic, academic and clinical status. This enables the reader to get a clear picture of the targeted group being interviewed. In addition it demonstrates homogeneity of sample and inclusion criteria (Barker, Pistrang & Elliot 1994, p.176/177).

	Therapist A	Therapist B	Therapist C	Therapist D
Age Range	25 – 40	40 – 55	40 – 55	25 – 40
Gender	M	M	F	F
Denomination or Faith Tradition	Roman Catholic	None	Agnostic	N/A
Orientation of Core Psychotherapy Training	Psychoanalysis	Integrative	Humanistic Person Centred Integrative Psychodynamic	Psychoanalysis
Modalities Used in Clinical Practice	CBT Psychoanalysis	Humanistic Person Centred CBT Psychodynamic	Humanistic Person Centred CBT Integrative Psychodynamic	Humanistic Integrative Psychoanalysis Psychodynamic Body Centred
Level of Training Attained	Masters QQI Level 9	PHD/Doctorate QQI Level 10	Masters QQI Level 9	Masters QQI Level 9

Accredited Body**	PSI APPI	IACP	IACP	PSI ICP
Years Practicing	7 Years	10 Years	6 Years	8 Years
Yrs Working with Interpreters	2 Years	3 Years	3 Years	3.5 Years
Is participant also an accredited supervisor?	No	No	No	No

APPENDIX 4: SEMI STRUCTURED INTERVIEW

QUESTIONS

1. In the therapeutic sense what type of role did the interpreter take on?
2. Do you find the presence of an interpreter useful or not useful?
3. Do you experience any differences with having an interpreter in the room?
4. As a therapist, how has it affected you?
5. Does cultural ways of being in the therapy differ, such as expressing themselves, behaviour, eye contact and if so how?
6. Does the language barrier affect therapy as in vernacular or miscommunication with words?
7. Has the interpreter at times not translated back certain things the client has said and why?
8. With Transference/countertransference, do you find that this happens between the client and interpreter and if so what happens between the client and therapist?
9. Do the interpreter and the client end up having the therapeutic relationship and how do the therapist and client get this, if at all?
10. What is it like working on an instinct or gut feeling on a somatic level?
11. Are there any other issues that arise?

Questions Added as per Individual Participant

12. When you say they would over step the boundaries, how would you handle that within the session?
13. In what way did you feel that it was a block?
14. So you would allow the interpreter to have their own input in the room with the client as well?
15. Would they often ask you for medical advice?
16. If that happens are the therapist and the client able to eventually build up the relationship or not?
17. Does the client ever look at you when you are talking or do they always look at the interpreter?
18. You were saying the interpreter does not have the qualifications that the therapist would has, but do you feel that they may be in a way take on the role of the therapist without actually being the therapist?
19. In your own experience has the interpreter ever, when the client has been talking about something difficult has the interpreter maybe consoled them within the room and is that a part they are allowed to take on?
20. When you were saying that the interpreter may want to say, its okay, its fine, you're going to be fine, has that ever happened?
21. Do you find that the interpreter or the client would converse outside of the therapy room at all?

APPENDIX 5: EMAIL – INITIAL CONTACT

To Whom It May Concern,

My name is xxxx xxxxx and I am in my final year studying BA (Hons) Counselling and Psychotherapy with Dublin Business School. I am conducting research in the area of Counselling and Psychotherapy surrounding the challenges and barriers of working with different cultures that do not have English as their first language and the need of an interpreter in the room. I am writing to inquire if you have any counsellors who work with interpreters with a minimum of two to three years consistent experience. If so, I was wondering if they would consider taking part in the research by meeting me for a one to one interview to gain an understanding of their experience working within this area.

I have an information sheet which I can present to them should they be interested in taking part. I can be contacted at either by email xxxx or by telephone xxxx, should you feel you can help me within this area of research.

I'd like to thank you for your time and look forward to hearing back from you at your earliest convenience.

Kind regards,

xxxx xxxxx