

**The challenges and opportunities of  
interpreter-mediated psychotherapy,  
theoretical considerations, research results  
and clinical experience**

Hanneke BOT

*Institute for Mental Healthcare De Gelderse Roos  
dept. Phoenix, the Netherlands*

IN MENTAL HEALTH CARE, at least in the Netherlands, there is a general hesitation to start psychotherapy with foreign patients, especially when asylum seekers, refugees and other migrants from non-western countries are concerned. Language barriers are usually mentioned to rationalise this reluctance. The evidence that interpreters can help carrying out psychotherapeutic treatment is not widely known and even less acted upon. This is a problem, as in this way a large group of patients who do not speak Dutch on a sufficient level, cannot profit from a treatment that may have been useful to them (Rohlof, 2006).

I first go into the question that precedes the involvement of interpreters: shouldn't patients speak the *lingua franca* and is psychotherapy a useful thing to offer to patients who are apparently inadequately integrated in society? After that, I say something about the type of interpreters I'm working with in the Netherlands and who this paper is about. I then continue describing the practice of interpreting in therapeutic dialogue and its specific challenges. I conclude with describing how therapists and interpreters can adapt their strategies in order to optimise the therapeutic character of the dialogue.

1. SHOULDN'T PATIENTS SPEAK *THE LINGUA FRANCA* AND IS PSYCHOTHERAPY USEFUL AND/OR NECESSARY FOR (RECENT) MIGRANTS?

In the Netherlands, and I think I can say in most European countries, the trend is to expect from migrants that they learn to speak the *lingua franca* as soon as possible. Understanding and speaking the *lingua franca* in general also meets a therapeutic goal. It helps people to become independent of others when acting in the public sphere and as such is an anti-regressant and enhances emancipation. It also has a anti paranoid function: understanding half, or even less, of what was said can make people very suspicious. In the developmental psychological approach of migration, as described by Akhtar (1995, 1999), learning the *lingua franca* is an important factor that enables people to build a healthy relationship with their country of arrival. But in the consultation room, one is sometimes confronted with patients with whom one does not have a language in common. Asking from them to speak the language is not appropriate at that moment. Investigating why the patient does not (yet) speak the language, how this affects him or her, can and should be part of such a therapeutic contact. Is there psychological resistance? Is there a learning problem? Is there maybe a narcissistic problem, and does the patient not allow himself to make mistakes? Is the person not allowed to go to school? What does this mean to the person? It is quite possible that this results in the patient starting to learn the language. But it also possible that patient and therapist accept that at this moment this is not appropriate.

Migrants usually face problems that are unknown, or less known, to non-migrants. Migration itself is a major life-event, with at its core 'the sudden change from an average expectable environment to a strange and unpredictable one' (Akhtar, 1999: 5). Most migrants are confronted with discrimination and exclusion. Asylum seekers usually face, on top of that, traumatisations through war and other organised violence, fear and uncertainty because of long asylum procedures. There is a fair chance that this implies that migrants are more

in need of psychotherapeutic help than non-migrants<sup>1</sup>. So there seem to be sufficient reasons to offer a psychotherapeutic treatment to foreigners, also when they do not speak the language of the therapist yet. It is clear though, that this can not happen without the help of an interpreter.

## 2. THE INTERPRETERS AND THEIR ROLE

In the Netherlands the Ministry of Health has contracted the Dutch Interpreter & Translation Centre (TVcN) to provide interpreter and translation services in healthcare. This means that health workers can make use of interpreters, in person or via the telephone, at no costs to themselves or their institution. The Ministry of Health foots the bill; when asylum seekers are concerned, it is the Ministry of Justice. TVcN is a private company and a mediating office: the interpreters are all self employed. At this moment, TVcN mediates about 1200 interpreters and translators in about one hundred and thirty languages.

The level of professionalisation of interpreters has been a matter of concern for decades to the government, users of interpreting services and interpreters themselves. For a long time, many interpreters have been professional mainly in the sense that they were paid for their services and had a Code of Conduct to adhere to and a pledge of secrecy to keep. Most of them were completely self-taught.

A leap forward has been envisaged with the *Wet beëdigd tolken en vertalers* (Wet/Law btw; Law certified interpreters and translators) which came into effect on January 2009. The Law btw stipulates a Register of Certified Interpreters and Translators. 'Registered interpreter / translator' has thus become a legally protected profession. Interpreters and translators can register when they fulfil the necessary requirements and have sworn an oath. The law broadly defines

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<sup>1</sup> See the study by Veling (2008) which shows that the highly increased prevalence of schizophrenia amongst Dutch Moroccans is related to migration related stress factors.

which competencies interpreters and translators should have to qualify for registration: language competencies, background knowledge of the countries involved, attitude and skills. Moreover, they have to show evidence of good behaviour. If interpreters have followed specialised courses and training, this can be published in the Register as well. After five years, re-registration has to be done, depending on permanent education credits and a minimum number of working hours per year. This law has been prepared and designed by the Ministry of Justice. The law also contains the important clause that for legal professionals and the police the use of certified interpreters and translators is mandatory except in cases where there are no certified professionals available. Unfortunately this mandate does not include healthcare. It is thus possible, that unregistered, read: less qualified, interpreters will be more employed in healthcare.

This law is not going to change the level of professionalisation overnight. One of the biggest problems is the large number of 'exotic' languages, for which there are no testing faculties available and for which exemptions have to be made.

Apart from the legal and organisational background of interpreting in the Netherlands, interpreters in healthcare generally work in the following way.

They interpret in the consecutive mode. Some of them actually master simultaneous interpretation, but usually patients, and most therapists too, find that very difficult to cope with.

They interpret everything the therapist and his patient say. They are not supposed to answer questions for the patient; they should not give opinions; they should not give 'cultural information' and they should not befriend the patient.

Their attitude is one of modesty, leaving the therapist and patient the floor, asking clarifying questions only, not too much expressed emotion.

The emphasis in the interpreters Code of Conduct is on giving equivalent translations, neutrality and non-partisanship and this has resulted in the above described way of working. In the Code of Conduct, the complexity of these concepts is not emphasised. And, as

most interpreters still have little training, most of them do not reflect in detail upon their role and attitude. The users of interpreter services have usually no training at all in the ins and outs of interpreter mediated talk. The result of this is that interpreters and their users have little insight in the subtle ways in which interpreter mediated conversation is in fact three party talk. Actually, most interpreters and their users alike, act as if interpreters are translation machines while in fact, interpreting is interaction, as Wadensjö (1998) put it so nicely. This is a pity as, I think, based on my own clinical experience and empirical data, the (therapeutic) quality of interpreted interaction improves when all participants acknowledge and act upon this interactive reality. This is not to say that I disapprove of the above described way of working – it is only that even while working along these lines, the interpreter does have an influence on the way the conversation proceeds and this is often neglected.

### 3. INTERPRETING IN PSYCHOTHERAPEUTIC DIALOGUE

On the basis of the literature and my involvement with interpreting and mental healthcare as researcher and clinician, I have identified a number of characteristics of therapeutic talk that are problematic for the, unprepared, interpreter and the therapist working with interpreters. I describe them as: the therapeutic relationship; the structure of the session; translational difficulties; and the role of norms, values and beliefs.

#### 3.1. THE THERAPEUTIC RELATIONSHIP

In most therapies, there is a heavy emphasis on the therapeutic relationship as a very specific and important factor, responsible for the successful outcome of therapeutic treatment.

The relationship between therapist and patient is an intimate one: the patient talks about issues he may never have shared before; he may talk about shameful or guilt ridden events and feelings. The therapist

on the other hand, does not disclose anything much about his own personal life. The therapist will explain his way of working, so the patient knows what he can expect. But the therapist will not disclose opinions, judgements about patients' stories or personal information. There is a wealth of literature about this topic in psychotherapeutic literature. The difference between 'boundary crossing' and 'boundary violation' (Gutheil & Gabbard, 1993) is an important one in this respect. A 'crossing' is a descriptive term, neither laudatory nor pejorative and is used to describe any divergence from the therapeutic rules. A 'violation' is a harmful boundary crossing. Proffering an opinion for example, is always a boundary crossing but does not have to be a boundary violation. It all depends on the situation: the patient, the diagnosis, the phase of the treatment. Therapists are supposed to be able to judge the situation and know what to do. It is my experience that interpreters, who have been trained to be neutral and impartial, have a hard time recognising when a boundary crossing is allowed. An example from my own clinical experience is the following.

I was working with a female patient from Chechnya with a paranoid psychosis, focussed at 'the Russians'. As there was no interpreter in Chechen available, I had to work with an interpreter in the Russian language. The patient asked the interpreter, in Russian, where she came from. The interpreter asked me whether she could answer the question. This was fine with me, as I knew she was Dutch and I hoped this would alleviate the patients' mistrust. The interpreter told the patient she was Dutch and had studied Russian here at the university. But then a discussion followed between interpreter and patient. The interpreter told her that she had been in Russia several times, that just recently she had received a present by mail from Russian friends, et cetera. I asked her what the discussion was all about and asked her to stop the conversation.

I discussed the event with the interpreter. For me it was absolutely clear that telling her Dutch origin, was enough information. The 'golden' rule to 'never volunteer information' that my supervisor had 'indoctrinated' me with during my training, resounding in my ears. The interpreter however, noticing that she had some room for a

personal conversation, did not draw that line. By giving more personal information, she drew attention to her personal life, inviting more questions from the patient, with the risk that a discussion about the interpreter was going to emerge, resulting in ‘interesting talk’ instead of therapeutic work.

In this case, there was no real harm done: a single mistake rarely means the therapy is at a loss. Still, it is an important issue. The distance between therapist and patient makes it easier for the patient to disclose difficult material, which he would never tell a friend (Takens, 2001). For that reason, distance has to be kept. Interpreters who befriend the patients they work for – and this happens not rarely – hamper proper therapeutic work.

Another aspect of the therapeutic relationship concerns the concepts of transference and countertransference. These are complicated psychoanalytic concepts that have found their way in general therapeutic thinking. Transference refers to patients’ feelings regarding the therapist, but which have their origin in patients’ own core feelings; while countertransference feelings are therapists’ own feelings regarding the patient. (Counter)transference thus does not deal with behaviour, but with (often unconscious) feelings and fantasies about one’s interlocutors. In interpreter mediated therapy, the interpreter is part of these (counter)transference feelings. The patient will have feelings regarding the interpreter and vice versa; the therapist has to be aware of these and has to be able to contain them. On top of that, the therapist has to be able to deal with the ‘narcissistic blow’ of having to share the transference with the interpreter, in a professional way. In some therapies, (counter)transference feelings are explicitly discussed between therapist and patient. The question is, whether this should also be done including the interpreter. Haenel (2001) describes how (counter)transference feelings between patient and interpreter can help or hamper the therapy. He describes how a young asylum seeker is very quiet and hardly speaks when the session is mediated by a older male interpreter from the patients’ country. When this interpreter is not available and is replaced by a motherly female interpreter, Haenel observes: ‘mit spürbarer Erleichterung sprudelten jetzt die Worte förmlich aus ihm heraus, als

wäre ein Bann gebrochen and als dürfte das, was zuvor beenzt zurückgehalten werden musste, sich jetzt vorbehaltlos ergiessen' (2001: 312). Haenel concludes that the male interpreter had seemed like the patients' stern father, while the young patient had found his empathic mother in the second one. It remains unclear though, from Haenel's article, whether these are his own inferences or whether these feelings have been mentioned by the patient or even maybe have been discussed in the therapy and possibly with the interpreter. The main issue regarding (counter)transference feelings including the interpreter is not whether they exist, there is no denying of that, but how to deal with them. It is clear that interpreters do not have it in their job description to discuss these feelings, nor are they trained to recognise and how to word them. It is for these reasons that I myself am prudent in this matter and will not draw the interpreter in the discussion.

Another important issue in the attitude of interpreters which concerns the relationship is on whose side they are. In the Netherlands, interpreters come from an independent agency, for them the patient and the professional user are both their clients. I think this means that they are on both sides: when interpreting patients' words, they are on the patients' side; when interpreting therapists' words, they are on the therapists' side: a sort of 'shifting partisanship'. This implies that the interpreter should agree with the approach the therapist chooses; he/she should shadow the attitude of the therapist. But he/she should not form a bloc with the therapist that could be perceived as 'two against one' by the patient. And the same applies in the relationship between interpreter and patient.

On basis of the above, I have developed the following preferences for the cooperation with an interpreter.

If a patient words his feelings towards the interpreter, and usually this is in a critical way and about his/her behaviour e.g. the interpreter is not quick enough, the interpreter does not translate well (patients usually speak some Dutch), I will pay attention to it. I will say for example: 'well, apparently it is difficult for you to wait for the translation', or 'the interpreter needs some time to do his/her work, can you try to be patient'. Or 'can you try to say it again,



maybe in different words, so the interpreter understands?'. Or 'it must be difficult to feel dependent on someone who does not translate it as you like' all depending on what type of patient and problem is at hand. In fact, this shows how an interpreter as a third party brings in the 'outside world' in the sessions and how this can be used by the therapist to further some therapeutic issues, like: can the patient cope with feelings of dependency or as an exercise of problem solving procedures.

My experience is that both patients and interpreters appreciate dealing with these potential face threatening situations in such an explicit way.

I do not ask the patient nor the interpreter about their (counter)transference feelings regarding each other. But I do pay attention to possible signs of these feelings and keep them in mind as hypotheses about what is going on with the patient.

In general, I feel most at ease when the interpreter reflects the emotions that emerge during the session in a modest way. When patient and therapist laugh, the interpreter smiles. When the patient cries, the interpreter keeps a low profile. When the patient is very angry and utters 'bad words', the interpreter may show some shock. I have noticed sometimes that the interpreter laughed about something the patient said, even before he had translated it. In that way, the interpreter set the mood: he decided that it was something to laugh about. I prefer the interpreter to follow the reaction of the primary speakers: after it has been translated, the participants can decide whether it is to laugh about or not, and the interpreter can follow. All this implies that interpreters have to be sensitive to the subtleties in therapeutic behaviour. Some training in the specifics of therapeutic talk, may be necessary to help them to achieve this.

### 3.2. THE STRUCTURE OF THE SESSION AND SEATING ARRANGEMENT

Working with an interpreter does influence the structure of the session to a great extent. The interpreter needs time to translate and he/she needs the turns to be kept limited. Although therapists mostly do understand that shorter turns make it easier for interpreters to

translate well, I notice a tendency amongst them not to stop the patient when he makes long turns. This is especially true for trauma treatment – when one is usually happy when a patient starts to talk about what has long been hidden. There is a dilemma here: stop the patient with the risk of discouraging him to continue his story, or let the patient talk and risk inadequate translations?

In my research data there was a very clear example of a patient who was difficult to stop, resulting in a lot of overlapping talk and in a large percentage of mistranslations finally ending in a complete misunderstanding which, by the way, was not explicitly noticed by the speakers involved. The patient felt offended, the therapist could not understand what was wrong and the session ended unsatisfactorily, meandering from one subject to the other, never really touching ground again. I concluded that 'as trauma treatment deals with patients who often have a history of being unheard, misunderstood and not respected, this is a very unfortunate thing to happen' (Bot, 2005: 253).

I concluded from this case, that it would be better to stop the patient, than to misunderstand, as I felt the general misunderstanding / alienation that arose from that session, would hamper proper therapeutic work. Stopping the patient, interrupting his flow, is however quite an intervention: the patient has to be able to bear it. In some cases, the patient will continue talking and one has to accept that the quality of the translation will drop. Being able to stop talking, to cut the trauma story in pieces and thus control it, requires skills that not every trauma patient possesses but that he may learn during the treatment. At the same time, the external pressure due to the interpreter to control the story may also help the patient to do so.

Another structural aspect of the session is the seating arrangement: where should the interpreter sit vis-à-vis the therapist and the patient? There is hardly any research evidence on this aspect. From the interpreter's point of view, both therapist and patient are his clients, and the interpreter should thus sit at an equal distance from both. Therapists sometimes favour a position of the interpreter behind themselves, or behind the patient, to be of least influence on the session. From a theoretical point of view I usually relate this aspect

to Bion's basic assumptions theory (Bion, 1961). Bion points at the fact that the formation of sub-groups ('pairs') within a group can have disruptive effects on the functioning of the group as a whole: more specifically he assumes that it hampers the formation of a 'working group' which is his terminology for a group which members cooperate properly towards a mutual goal.

In my own research I have analysed two sessions in which the interpreter sat close and a little behind the therapist, the two of them at a relatively large distance from the patient. The objective for this arrangement was to allow the patient to see the therapist and interpreter in one glance. This would allow direct contact between the therapist and the patient and it would show that 'interpreter and therapist form one front' – the therapists' words (Bot, 2005). The seating arrangement did not have the effects that were envisaged, which I concluded from the fact that both patient and therapist were talking about one another in the 3<sup>rd</sup> person pronoun and the general alienation that dominated in the sessions that I described in detail in my dissertation. I concluded that on the contrary, the seating arrangement might even have contributed to the estrangement. In terms of Bion's theory, therapist and interpreter forming 'one front' may imply that the therapist and the interpreter form a 'pair', which would make it difficult for the three of them to function as a 'working group'.

Wadensjö (2001) found that it is helpful for the patient to see the therapist and the interpreter in one glance – comparing it to a situation in which the patient has to look away from the doctor to see the interpreter. But she also states that 'the interpreter – placed centrally between the parties – forms part of a communicative radius shared by all those present' (2001: 81) and that this makes the encounter into a 'much more focused communicative event' (2001: 80) which she feels positively influenced the proceeding of that session.

The little research there is points at the importance of equal distances between the three parties. Therapy has to take place in a safe environment: treating each other as equals; being able to see one another seems to be one of the prerequisites for that.

### 3.3. TRANSLATING THERAPEUTIC TALK

Psychotherapy is the 'talking cure' – it is largely about words. This makes it impossible to ignore the translation aspect of interpreting in psychotherapeutic sessions. There is a lot to say about translation and translational difficulties in psychotherapeutic sessions. I necessarily limit myself to mentioning just a few characteristic difficulties.

All corpus research points at large percentages of somehow inadequately translated turns by interpreters. In my corpus, I noticed that percentages of up to 40% of the turns of a session were inadequately translated. Not all these inadequate translations had dramatic results: some problems were solved in closely following turns, sometimes redundant information was omitted without changing the general therapeutic line.

Problems were often solved by a certain tenacity of the therapists as I show with the following example:

Therapist: [...] what does it mean to you, that you do not have this yet?  
Interpreter: *what kind of problem does it cause to you*

The patient has mentioned feeling worried because his residence permit has expired. The therapist, who has explored the practical and realistic aspects of this issue, concludes that at this moment there is no real reason for worry and then he asks the above question, now focussing on the feelings the patients has. The interpreter however, translates it in practical terms – 'problems' – and the patient thus answers with, again, mentioning his practical worries. Important here is that this therapist does not take this as an indication that the patient does not want to talk about psychological aspects, but he explores further, probing for meaning. After several turns, he says 'but you still do not trust it, it seems' after which the patient starts talking about his basic mistrust in people and the world and a therapeutic theme emerges.

It is important that therapists understand that an unexpected reaction from the patient may well have to do with some translation problem.

The patient above answered very adequately to the question he heard from the interpreter. If the therapist had concluded, that this patient apparently was not psychological minded – he would have done injustice to the patient.

Another translation problem relates to questions formulated by the therapists. Often these questions have a rather ambiguous character, or a second question only differs in a subtle way from the foregoing. Often questions are translated as statements, or the subtle differences are missed which leads to a repetition of the same translation. This changes the therapeutic character of the dialogue: the therapist is here changed from someone who encourages the patient to explore his inner self with the help of these questions, into someone who knows what is going on with the patient.

Also, it was remarkable that a large number of the utterances in which the speaker included some relationship between himself and the other primary speaker, was left untranslated. I herewith mean introductions such as ‘I heard you say’, ‘do I understand you well’, or a patient’s ‘I told you earlier already’. Apparently, the interpreters did not see such remarks as essential information that needed to be rendered. The interpreter here introduces a specific point of view into the dialogue; a view in which remarks of this kind are thought to be unimportant and not worth translating. This is problematic as psychotherapy essentially is a treatment that takes shape in the relationship between the therapist and the patient. It is my experience and that of many other colleagues that this is a difficult issue in the treatment of asylum seekers and refugees. They often expect that being treated means ‘someone doing something to you’, instead of doing something together. The interpreter, apparently sharing patients’ ideas more than therapists’ ideas, sieving this kind of interventions out, is thus contributing to the difficulty of doing psychotherapy with foreign patients.

Sometimes, interpreters made systematic mistakes. In one of my sessions, the interpreter systematically leaves out all reference to religion, whether it be idiomatic phrases like ‘god forbid’ or the patient talking about practicing religious rites. When discussing the transcripts, the interpreters, those who participated in this study and

others, told me that they do this because it would sound ridiculous and exaggerated when translated into Dutch. The idea behind it is that people from countries in which religion is part and parcel of public life use this type of expression frequently and as a collective cultural norm, i.e. without specific concomitant individual religious ideation or belief. In Dutch however, it is not the custom to use such terms in daily life. The interpreters believe that translating these terms would lead Western European therapists to, wrongfully, interpret them as expressions of intense religiosity. In this particular session however, this systematic omission led to serious communicative problems: the therapist did not come to understand the intense and active religious feelings of the patient which led him to ask questions which offended the patient a great deal. What in fact happened during these sessions is a misrepresentation of part of the patient's identity. By leaving out the religious inspired figures of speech used by the patient and most of the references to religious practice and ideation, the therapist has not been able to understand the fact that religion is very much alive to this patient.

It seems defensible that when a person uses figures of speech like 'God give' or 'God forbid' from time to time, little harm is done when they do not get a close translation. However, this applies to everything – as I have shown in other parts of my dissertation. Divergent renditions can easily go unnoticed, especially when they are haphazardly distributed, and may not have disruptive effects. However, here we see that an accumulation of a certain type of divergence leads to an almost complete disappearance of this issue, the patient's religious feelings, from the dialogue. And this leads to a communicative breakdown in the end. We thus see that not rendering these terms is, wrongfully, interpreted by the therapist as an absence of religiosity.

The interpreter here adopted a target oriented translation strategy – while I think in interpreting there should always be a source – orientation. Only when the interpreter is faithful to the source – both patient and interpreter – the two primary speakers can sort out their (communicative) problems and differences.

### 3.4. THE UNCONSCIOUS, NORMS, VALUES AND BELIEFS

In my dissertation I concluded that, in the sessions that I analysed, interpreters' renditions usually took the form of 'reported speech' ('he said I have a headache') and even of 'constructed dialogue' (by changing, omitting, adding information to the renditions). The examples I described in the paragraph above, show that in this (re)construction, the interpreter's worldview enters the therapeutic dialogue. This relates to a statement made by Yahyaoui in which he rejects working with an interpreter as '*au bout du compte on ne sait plus si ce qu'on traite est le vécu du patient ou celui de l'interprète*' (1988: 60). Englund-Dimitrova, in considering cognitive processes involved in consecutive interpretation, argues for 'the inclusion of a decision component in these processes (of diverging from the original utterance, HB)' (1995: 73). She refers to decisions on leaving certain (parts of) utterances unrendered or on adding information based on 'the interpreter's subjective evaluation of the situation and the utterance at hand [...]' which 'is not necessarily congruous with the intentions of the speaker' (1995: 75). Both Englund-Dimitrova and Yahyaoui indicate that interpreters introduce something of their own, either consciously or unconsciously.

I have shown that systematic and/or repetitive divergence can lead to situations in which for example part of the identity of the patient is misrepresented (secularised). In the same way the intentions of the therapist can become misconstrued. This happened for example when a therapist emphasised the importance of 'talking about one's problems', the interpreter emphasised the positive effect of 'not talking about one's problems' to the people close to the patient. I have thus seen interpreters' translations sometimes steering the dialogue away from the therapeutic perspective. The conclusion that an interpreter forms an integral part of this type of psychotherapy cannot be escaped. This implies that interpreter-mediated psychotherapy is inherently different from monolingual psychotherapy.

It is important for therapists conducting interpreter-mediated psychotherapy to be aware of the fact that the dialogues are influenced by the interpreter: through the act of translation – the differences

between the two linguistic systems; deliberate choices to diverge in the renditions and through the interpreters own cognitions and emotions and the thus emerging non-deliberately made divergent renditions. This means that the therapist should take care in attributing what happens in the session to the interaction with the patient alone. But also, the knowing therapist can adapt his interventions in such a way that they are more easily understood by interpreters: by phrasing grammatically correct; by phrasing questions as questions, sometimes by explaining better why they say what they say. For example, when talking about the importance of talking about traumatic experiences, I now say something like 'I understand that it is difficult for you to speak about this in your family and of course you do not want your children to know these terrible things. But if they have no idea of what happened to you, they can never understand why you are sometimes so irritable or angry. Could you find a way of telling them about these things, adapted to their age and understanding?' In this way it not only becomes clearer to the patient, but also to the interpreter.

#### 4. COOPERATION BETWEEN INTERPRETERS AND THERAPIST

For an optimal cooperation between therapists and interpreters it is important that therapist and interpreter approach the patient in the same way. This does not imply that they form a bloc: the interpreter is there for the patient, just as well. In general, the interpreter shadows the emotions that reign in the session – the interpreter does not take the lead.

To optimise translational quality it is important that therapists learn to phrase their interventions clearly. Sometimes this means that interventions have to be explained: not only to help the patient understand the rationale of the intervention, but also to help the interpreter to translate well.



The interpreter brings in the ‘outside world’ into the therapeutic session. This can help to make some therapeutic themes more explicit. For example dependency issues, trust and mistrust of compatriots, play a role right in the session and thus become more easily accessible. I have heard ex-patients say that the necessary cooperation with the interpreter helped them to become more trustful of their compatriots – a therapeutic experience. The structure that working with an interpreter imposes on the session – keeping the turns short, allowing space for the interpreter – can help the patient to structure his own thoughts and it can help him to control his storytelling. Irritations that arise between patient and interpreter can lead to an immediate exercise in problem-solving behaviour. The group dynamics that arise in interpreter mediated psychotherapy can thus be used to further the treatment.

Only if therapists and interpreters recognise the interactional reality of interpreter mediated psychotherapy, they will be able to cooperate optimally, each in their own roles and be able to fully use its potential.

## 5. FINALLY

I have the impression that it is not only language barriers that keep psychotherapist from treating migrants, especially asylum seekers and refugees. Both patients and (potential) therapists see the difficult position in society as an impediment to psychotherapeutic treatment. The situation of the average asylum seeker – serious traumatic experiences in their home country, forced migration without belongings and usually without family, insecurity about the asylum procedure, unable to speak the language and no right to schooling nor to work, discrimination – is very distant from the situation of the average psychotherapist. The confrontation of these very different existential positions leads to strong feelings of unease with the therapist (Hafkenscheid, 2004). I noticed that the often massive traumatisation of patients leads to shock or even terror, disgust and

compassion with many therapists; to the idea to be of no use as psychotherapist as real sadness and mourning are concerned. The traumata that patients have suffered are often of such a magnitude that therapists can hardly believe that someone could learn to cope with them. The fear of being sent back to one's country of origin and to be imprisoned again – or worse – may be so real that advocacy may seem more useful than therapy. On top of that, in the discussion about migrants in healthcare, the 'exotic' is often emphasised – this also gives therapists the impression that their usual techniques are of no use. It seems that these ideas and feelings exist even before the migrant patient has entered the consultation room. When it turns out that he in addition does not speak the language, the decision to turn him down for psychotherapeutic treatment is easily made.

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