A Training Program to Increase Collaboration Between Interpreters and Therapists in Psychotherapy with Resettled Refugees

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Abstract

Drawing from the framework of community-academic partnerships, we describe the development and implementation of a training module to increase collaboration between interpreters and therapists in interpreter-mediated psychotherapy with refugees. Beginning with community engagement with local agencies and leaders to identify barriers to accessing psychotherapy services in the resettled refugee populations, this project involved multiple layers of collaboration to include multiple perspectives. The program was funded by a local community foundation and was implemented in three phases. In the first phase, we identified key community partners and stakeholders with first-hand knowledge of the needs of refugee populations. Phase two involved a two-day workshop for student therapists from different disciplines and interpreters working in the field. Phase three included a follow up to re-assess challenges in the field and refine our training. The need to build early collaboration between therapists and interpreters was highlighted throughout the development and implementation of the project. We discuss the project's impact, challenges encountered, and implications of lessons learned in developing community-engaged partnerships for graduate programs as a way of promoting social justice in practitioner training.

Keywords: collaborative training, community-academic partnerships, interpreter-mediated therapy, therapy with resettled refugees

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In this article we discuss the development and implementation of a community-engaged program to build collaboration between spoken language interpreters and graduate students in Family Therapy and Social Work assisting resettled refugees. Access to mental health care for resettled refugees is often limited by a number of factors including language barriers and inadequately trained clinicians in culturally responsive practices (Morris et al., 2009). This is especially problematic for refugee populations who have experienced complex traumatic experiences and would benefit from appropriate mental health care (George, 2010; Kirmayer et al., 2011). Though federal mandates require language assistance to be provided in health care settings, it is not always enforced or uniformly practiced (Chen et al., 2007; Clarke et al., 2019). Additionally, graduate students in mental health programs are not always trained in working with interpreters even though there is an increased likelihood of needing language assistance in clinical practice. As we re-think western models of mental health interventions for refugees (Borwick et al. 2013; Kira 2010; Murray et al. 2010; Nickerson et al. 2011; Watters 2001), developing ways to foster intentional collaboration between interpreters and mental health clinicians is vital to effective, culturally responsive practices.

Motivation for this project was initially based on our own clinical experiences, engagement with refugee community leaders, and advocates for language access in a resettlement city in the Northeastern United States. This city has historically resettled large numbers of refugee populations from predominantly conflict- ridden countries. Though services for transitions in resettlement exist, through our practice and scholarship we identified a major need for reducing barriers to mental health care, particularly, psychotherapeutic services. The first author was a faculty member and the second author was a doctoral candidate in a graduate family therapy training program at a private university in this city at the time of this project. Our scholarship is focused on developing community-engaged and family systems-based interventions for low-income refugee and immigrant communities. This project emerged in conjunction with other efforts to increase knowledge of mental health and access to psychotherapeutic services in resettled refugee communities. After a brief overview of existing literature, we describe the steps involved in developing and implementing our training project, challenges and rewards in each step, and conclude with a summary of lessons learned and implications.

Interpreter-mediated psychotherapy with refugee populations

Interpreters are professionally trained to translate a spoken language and serve as a bridge between those who do not share common languages (Paone & Malott, 2008). Interpreter- mediated therapy, or use of interpreters in psychotherapeutic services, can decrease linguistic and cultural barriers in working with those with Limited English Proficiency (LEP), especially when providers are not themselves proficient in client's spoken languages (Chang et al., 2020). While literature on use of professional interpreters in psychotherapy is limited (Mirza et al., 2017), research in psychiatric and medical settings has suggested that when trained interpreters were used, fewer mistakes in diagnosis and treatments occurred (Bauer & Algeria, 2010). Use of trained interpreters was also associated with increased quality of care and greater satisfaction among clinicians and patients (Flores, 2005). However, despite a federal mandate for providing interpreters, there is no uniform set of competencies guiding professional interpreters resulting in inconsistencies in practice (Mirza et al., 2017).

Recently, some attention has been directed to developing practice guidelines for working with interpreters in psychotherapy (Searight & Searight, 2009). Research studies using qualitative methods also have begun to provide perspectives of interpreters in the therapist-client-interpreter triad (Mirza et al., 2017). Practice guidelines for working with interpreters written for mental health settings by scholars and agencies in different countries appear to converge on general principles of clear and open communication between interpreter and therapist to discuss roles, boundaries, confidentiality, cultural exchange, and opportunities for de-briefing (Clarke et al, 2019; Paone & Malott, 2008; Searight & Searight, 2009).

Additionally, while most interpreters are trained to work in medical settings, unique factors of working in psychotherapeutic settings are not always incorporated in training programs (Hseih et al., 2013; Mirza et al., 2017). This setting is distinct from that of a medical setting due to the complex relational and emotional processes that take place in psychotherapy. For example, while it is common for an interpreter to interpret verbatim in a medical setting and for appointments to be short and often with different providers, psychotherapy is a longer-term process relying on the strength of the therapeutic relationship. This way of being may be different, or even uncomfortable for interpreters who are used to interpreting in a medical setting (Costa, 2017; Miller et al., 2005). That is, the intensity of emotions, use of therapeutic interventions such as silence or escalation of conflict, may be quite different from the interpreter's experience in a medical office.

Often, interpreters used for language access in the medical or mental health setting for refugee clients are unique in a variety of ways. These interpreters are frequently members of the refugee community themselves and have access to cultural knowledge that someone outside of the community may not. When utilizing interpreters with refugee populations, it is important to not only be attuned to language, but also specific dialect and cultural nuances. Not only are the interpreters "necessary and important" in the mental health therapy process in terms of language comprehension, but interpreters also play the unique role of "cultural brokers" (Gartley & Due, 2016). Specifically, interpreters, in their role as cultural brokers have insider knowledge about goings on in the local refugee community as well as firsthand cultural knowledge that the provider may or may not have access to. Gartley and Due referred to the interpreters as "a bridge between the mental health worker and their client" (p. 36). That is, interpreters may provide a sense of comfort or familiarity to the clients that can act as a catalyst to the therapeutic alliance.

Another unique aspect of language assistance with refugee populations is the fact that the interpreters may have experienced similar life events as the clients that they are interpreting for. Given this similarity, emotional reactions and potential re-traumatization in sessions may be experienced by interpreters (Mehus & Becher, 2016). However, some authors have suggested that the distress for the interpreters was usually short-term, and the benefits of a "cultural liaison" and someone who truly understands the client's lived experience outweighed potential difficulties in the triadic relationship (Miller et al., 2005). Thus, the risks of re-traumatization may be reduced with an intentional, supportive relationship and provision of supervision for both therapists and interpreters in this context.

Clearly, the effectiveness of interpreter-mediated therapy, especially with refugee populations, is predicated on the ability to develop a trusting, safe, and intentional collaboration in the triadic relationship of the therapist-interpreter-client (Becher & Weiling, 2015; Costa, 2017). However, to our knowledge, there are no known curricula in graduate mental health programs that train students to collaboratively work with interpreters. From a social justice perspective of providing mental health treatment, this gap in training is especially poignant in decreasing disparities in access to quality psychotherapy services. The training project presented in this article was conceptualized as a way of addressing this issue in our own graduate program as well as in interpreter training agencies in our region. Training students to engage with community collaborators and empowering them in advocacy work are essential components in a social justice-oriented curricula (Sanabria & DeLorenzi, 2019). When students learn to collaborate and "share power" with communities they serve, the role of a mental health professional expands as a co-learner and not just as an expert (Becher & Weiling, 2015; Goodman et al., 2004). Examples of incorporating service learning and experiential (e.g., Ali et al., 2008) and advocacy (e.g., Murray et al., 2010) training in counselor education, and immersion education programs in family therapy (e.g., Platt, 2012) provide some strategies. We based our program within the framework of community-academic partnerships (CAP), which are known to play a vital role in health promotion and increased utilization of health services (Wells et al., 2006; Brush et al., 2019). The framework of community-academic partnerships has been used extensively to build research and service-learning programs across disciplines with varying levels of collaboration (Drahota

et al., 2016). Given the potential to increase outreach, build trust, and enhance training, CAPs can be used as a effective strategy in decreasing health disparities (Brush et al., 2011).

Description of the training project

Background

As stated earlier, the training project was developed through continual efforts to enhance access to psychotherapy services in the resettled refugee communities located in a resettlement city in the northeastern part of the United States. While some formal programs and informal networks existed to support their resettlement, attention to mental health services in general was lacking. This deficiency in the refugee resettlement programs in the United States has been widely reported (Brown & Scribner 2014). Given that large numbers of refugees have experienced severe disruptions, traumatic events, and significant shifts in their families, there is a need to extend services beyond their initial months of resettlement to include culturally appropriate psychotherapy services (Miller & Rasmussen 2017). The first author began establishing connections with the refugee community as a result of a qualitative study examining family experiences of resettled Iraqi refugees (Gangamma, 2018). Drawing from findings, the author reached out to various local organizations to better understand needs and barriers to seeking treatment. Over the course of one year prior to beginning this project, the author attended meetings with board members of local community centers run by refugees, immigrant advocacy groups, and a local language advocacy group. What emerged during these meetings was that while there was a major need for mental health services, in general, barriers related to transport, lack of knowledge of services, and language access limited the options available. Additionally, it was apparent that the graduate training of students specifically in the field of family therapy did not include curricula that might build awareness of these issues. In an effort to bridge this gap, we initially created, through a Memorandum of Understanding between the university and community agencies, placements for graduate students in community centers to provide free family therapy services to the refugee communities. Our agreement with centers included access to their trained case workers to serve as interpreters in sessions. Our therapeutic work was not just limited to working with our clients, but also included de-briefing and explaining treatment decisions to our interpreters. This is in line with recommended practices for effective interpreter-mediated therapy (e.g., Searight & Searight, 2009). However, in conversations with our interpreters we learned that these practices were not widely used, if at all, in other mental health care agencies.

These insights provided the foundation for our outreach to interpreter agencies. The first author initially approached a well-known, long running local interpreter provider and training service to understand their approach to interpreting in psychotherapy settings. Over the course of several meetings with leaders, trainers, and interpreters in this agency, a theme of inadequate training for both therapists and interpreters to work together in psychotherapy settings emerged. However, a key insight was that for successful collaboration to occur in interpreter-mediated therapy, this collaboration had to start early on in graduate family therapy training programs . Thus, the first author and the interpreter agency agreed to collaborate to bring together their unique resources to develop a training module that could be implemented in our city.

With the assistance of our university research offices, we applied and received funding from a community foundation that offered grants specifically for projects that engaged local agencies to serve marginalized populations. The original training development module was proposed over three phases - Module development; Implementation of module; and Follow-up and modifications to module. The long-term goal of the project was to establish sustainable relationships with community partners to continue training therapists and interpreters in interpreter-mediated therapy with refugees.

Project development and implementation

Phase One

Phase one of the project was spread over six months of planning meetings with various stakeholders including refugee community leaders and advocates, interpreter trainers, interpreters who worked in medical

or psychiatric settings, two graduate students, and the first author. During this phase, we discussed and studied: a. Unique circumstances and needs of the resettled refugee populations; b. Existing literature on psychosocial therapy with resettled refugees; c. Experiences of interpreters working in medical, legal, and health settings; d. Ethical codes guiding family therapists and interpreters; and e. Special considerations in interpreter-mediated therapy. Materials included academic literature, interpreter training manuals, relevant training videos available online, and role-playing skills in meetings. Though led by the first author, the meeting agenda was discussed in groups and were modified as new themes emerged.

A major challenge for the team in phase one was encountered soon after we received funding. Due to unexpected and unforeseen circumstances, the leadership of the interpreter training agency changed, and we lost a key member who had a played a vital role in the conceptualization of the project. However, the agency committed to continued collaboration with us. Over the six months of planning, there was a quick turnover of leaders and interpreters in the agency that collaborated with us. As a result, we did not have consistent members attending meetings, though there was some representation at all times. In these six months, the local office of the training agency also shut down with only one office remaining in another city in the region.

Noting these changes and recognizing the importance of maintaining collaborations with interpreters, we requested a revision to the original proposal to our funders to allow us more flexibility in including other interpreter agencies in the community. This revision was accepted, and we began to include other freelance interpreters who were serving the refugee community in the area. While these unexpected changes were difficult, the flexibility of our funders, the adaptability and persistence of our team opened up other opportunities for collaboration. For instance, our engagement with the freelance interpreters, who were also community advocates, provided more meaningful insights into mental health challenges facing their communities. This informed the content we chose for our training module in phase two.

Phase Two

Phase two included the actual implementation of the training module spread over two days in a workshop format. The aims and objectives of the training were determined by the team working in phase one. The overall aim of the workshop was to foster a collaborative relationship between interpreters and psychotherapists working with resettled refugees. The objectives covered areas of unique challenges of resettled refugees; cultural meanings of mental health and illness in refugee communities; roles of language interpreters and psychotherapists in mental health settings and their code of ethics; and developing skills for effective collaboration to provide culturally responsive psychotherapy. Advertisement and recruitment of psychotherapy students required assistance from the department and college administrative staff, while recruitment of interpreters occurred through our key informants in the community. A total of 25 participants including graduate students in departments of Marriage and Family Therapy (MFT) and Social Work, interpreters from local agencies, interpreter trainers, and partners from a local head start office attended.

The team invited speakers who had lived experiences of being either a refugee or an interpreter for resettled refugees and were able to discuss challenges regarding mental health and access to treatment. The authors and one instructor from the department of MFT whose expertise was in ethics in family therapy also led a few sessions. The first day was devoted to presentations, speaker panels with discussion of content areas, and time for networking. The second day focused on skill building sessions with participants divided into smaller groups to discuss specific case vignettes, culminating with role plays in the larger group. The workshop ended with a consolidation session and discussion on next steps with more time for networking among participants. Supported by funds from the grant, all participants received stationery, reading materials, and three meals with coffee breaks at the venue. The ability to provide for this made it possible for participants to stay in the premises for the duration of the workshop and build professional contacts with each other. Feedback forms were distributed to all participants in an effort to further refine our module. Participants noted the significance of this training with some remarking - "*The most important lesson from this workshop was the power of collaboration among therapist/interpreter and even with the*

client." And "*I am looking forward to my next session with my client who uses an interpreter so I can better serve my client. I came excited to use these new approaches because I knew NOTHING prior to this.*"

Formal and informal feedback from the workshop highlighted the need for increased communication and collaboration between interpreters and psychotherapists. In addition, the team gathered several insights from our two-day interactions with participants. Salient among them were the following: The collaborative relationship between therapists and interpreters needed to occur early in their respective training programs. There was a need to communicate each of our roles, delineate how psychotherapy was different from a medical visit, and specifically discuss challenges arising in couple and family sessions. In addition to clinical supervision that therapists receive, there was a significant need to provide ongoing de-briefing sessions to interpreters to manage reactivity, vicarious trauma, and prevent burnout. More training for therapists to work with interpreters over phone or video calls was needed. And most importantly, efforts to creating institutional level support at mental health agencies by reaching out to clinical supervisors and administrators would be crucial to sustaining collaborations between therapists and interpreters.

Phase Three

These insights were additionally corroborated by participants in a follow-up session in phase three which occurred three months after the workshop. All attendees from the workshop were invited to participate, however, only six were present. Attendees noted that the skill building sessions at the workshop was most helpful and provided suggestions for finetuning the training module. Specifically, it was suggested that the training be converted to a continuing education (CE) program so that it could reach a wider audience of therapists and supervisors. Additionally, outreach to agency leaders and administrators was suggested in order to build institutional support for therapist-interpreter collaborations.

Project outcomes

Following the completion of the three phases, and based on feedback received, the first author applied and received an extension of the grant. We proposed to conduct another workshop incorporating some of the feedback received. However, due to COVID-19 related restrictions on in-person gatherings, we continued our collaboration remotely with community leaders including interpreters who were former refugees, and curriculum developers and trainers in interpreter agencies. These meetings provided another platform to assist interpreter training agencies to better incorporate curricula on unique considerations for interpreting psychotherapy and family therapy sessions. A condensed version of the training module has been incorporated into graduate level courses on migration and mental health and global mental health taught by the authors. Finally, the authors collaborated with one of the speakers to publish a chapter on ethical guidelines for working with interpreters in family therapy.

Summary and Conclusion

A salient factor in the development and implementation of this project was that multiple levels of collaboration was required at different stages. This involved openness and willingness to learn from each other as opposed to one assuming an expert role. As noted above, however, challenges emerged at each stage that tested the team's adaptability and commitment. Successful completion of the project was also dependent on the funder's responses to our requests for changes to navigate challenges. Support from the authors' department and college was also crucial. For instance, the department provided an entire floor of classrooms for the two-day workshop which greatly helped in reducing costs associated with renting space. While the initial motivation was to develop resources to increase access to psychotherapy services for resettled refugees, lessons learned from this project have broader implications for social justice related training in academic programs, specifically in the field of family therapy that also can be adapted for other graduate mental health programs. The inclusion of graduate students in the development of the training module was important. As team members, students were in direct contact with refugee and interpreter communities that they would work with. This was instrumental in ensuring multiple perspectives were included – those of students who needed training, interpreters who were working in the field,

community leaders who essentially were our key informants, and of faculty who might incorporate the module into their curricula.

A significant challenge in community-academic partnerships is typically ensuring sustainability of the program (Brush et al., 2011). The team was cognizant of this challenge and addressed it early on as it was a requirement of the grant application. Developing a plan for sustainability at the start of the project and remaining flexible to changing contexts (especially during the COVID-19 pandemic) were important to ensure the collaboration did not end with the project.

There were several aspects of the collaborative relationship that our project did not address. For instance, while some authors (Becher & Weiling, 2015) have called for an intentional examination of power in the triadic relationship of therapist-interpreter-client, our training module did not specifically cover it. We noticed that the theme of power (or who is in charge in interpreter-mediated therapy) emerged several times during our planning and implementation. While we openly discussed the theme in our meetings, we did not devote time during our workshop to fully engage with it. Additionally, some of our attendees noted that our training may have reached a wider audience if we had included sign language interpreter agencies as well. This would be area for further consideration in future training programs. Finally, we conceptualized this as a service and training project rather than as a research investigation, which is commonly the goal in CAPs. While the emphasis on service provision enabled us to bring more collaborators into our work, we did not engage in a systematic study of the effectiveness of this approach. Several scholars have noted a need for more careful investigations into ingredients of effective interpreter-mediated therapy (Becher & Weiling, 2015; Hseih et al., 2015). We echo this call and hope that our continued partnerships with communities will provide more opportunities for future research.

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