

Interpreter-Supported Psychotherapy with Refugees and Asylum Seekers: Results of Qualitative Interviews with Psychotherapists and Interpreters on Opportunities and Challenges in the Triad

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Keywords

Interpreter · Psychotherapy · Refugees · Asylum seeker · PTSD

Summary

Background: Due to the large number of refugees showing a high prevalence of mental disorders, there is an increasing focus on the psychotherapeutic care of these people. Interpreters are generally needed to enable communication between therapist and patient. **Material and Methods:** Based on guided interviews, opportunities, challenges and recommendations for interpreter-aided therapy were examined from the psychotherapists' (n = 5) and the interpreters' (n = 3) point of view and analyzed following the rules of qualitative content analysis according to Mayring. **Results:** The interview partners named the necessity of legally regulated financing of interpreter expenses and the establishment of permanent interpreter pools and specialized therapy centers as external conditions for successful interpreter-supported psychotherapies. They emphasized the importance of a clear separation of roles, preliminary talks and follow-up discussions, the good match between patient and interpreter with regard to their cultural background, as well as full and accurate first-person translations. Within the triad, they underlined the importance of a harmonious relationship between therapist and interpreter. **Conclusions:** Successful interpreter-aided psychotherapy requires the structural framework and the skills and burdens of the psychotherapists and interpreters to be taken into consideration. Further empirical studies including the patients' perspective are needed.

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Schlüsselwörter

Dolmetscher · Psychotherapie · Flüchtlinge · Asylbewerber · PTBS

Zusammenfassung

Hintergrund: Aufgrund der vielen geflüchteten Menschen in Deutschland, bei denen sich hohe Prävalenzen für psychische Erkrankungen zeigen, steht die psychotherapeutische Versorgung von Flüchtlingen zunehmend im Fokus. Für die Psychotherapie mit geflüchteten Menschen müssen Psychotherapeuten in der Regel Dolmetscher einsetzen. **Material und Methoden:** Mithilfe leitfadengestützter Interviews wurden Chancen, Herausforderungen und Empfehlungen für die dolmetschergestützte Therapie aus Sicht von Psychotherapeuten (n = 5) und Dolmetschern (n = 3) untersucht und mittels qualitativer Inhaltsanalyse nach Mayring ausgewertet. **Ergebnisse:** Als äußere Rahmenbedingungen für eine erfolgreiche Psychotherapie zu dritt nannten die Interviewpartner die Notwendigkeit einer gesetzlich geregelten Finanzierung der Dolmetscherkosten, den Aufbau fester Dolmetscherpools sowie den Ausbau spezialisierter Therapiezentren. Die Interviewpartner betonten die Wichtigkeit einer klaren Rollenverteilung, des regelmäßigen Führens von Vor- und Nachgesprächen, der Passung von Patient und Dolmetscher im Hinblick auf den kulturellen Hintergrund sowie der vollständigen und genauen Übersetzung in der Ich-Form. Innerhalb der Triade wurde insbesondere die Bedeutung einer stimmigen Therapeuten-Dolmetscher-Beziehung zusätzlich zur Therapeuten-Patienten-Beziehung deutlich. **Schlussfolgerungen:** Bei der dolmetschergestützten Psychotherapie müssen der strukturelle Rahmen und die Fähigkeiten und Belastungen von Psychotherapeuten und Dolmetschern berücksichtigt werden, damit die Behandlung gelingen kann. Weitere empirische Untersuchungen unter Einbezug der Patientenperspektive sind notwendig.

Introduction

Refugees are, in terms of mental disorders, a highly vulnerable demographic group due to the extreme burden of war, organised violence in their home countries or trauma happening during their escape, as well as the burden of life in exile itself. Refugees often develop mental disorders due to disturbances caused by trauma such as post-traumatic stress disorder (PTSD) [Lindert et al., 2018]. The S3 guideline for PTSD recommends trauma-focused psychotherapy (PT) for treatment, while using medication as a support [Flatten et al., 2011]. Alongside PTSD, depression as well as anxiety-related and psychotic disorders are often seen in refugees [Lindert et al., 2018], for which PT is often prescribed.

To ensure the quality of refugees' psychological treatment, it is necessary to consider the aspects of language, culture and intercultural communication. In this way, the field of intercultural PT, in which the intercultural literacy of the therapist is a substantial precondition for the effective treatment of individuals with a migrant or refugee background [Schouler-Ocak and Aichberger, 2017], is becoming increasingly important [Storck et al., 2016].

Psychotherapeutic Treatment of Mentally Ill Refugees

According to the Asylum Seekers Benefits Act (ASBA), refugees have the right to medical benefits in the case of acute illness or pain during the first 15 months of their stay in Germany. By contrast with psychiatric treatment, PT is generally not considered to be acute care. In the case of refugees who are in particular need of care, i.e., who have experienced torture, rape or other forms of mental, physical or sexual violence, short-term PT treatments may be applied for as per article 6 of the ASBA [Metzner et al., 2016]. Refugees who have been in Germany for longer than 15 months may claim health benefits according to Social Code (SC) XII as well as PT, including long-term therapy, as may others who are insured under statutory health insurance (SHI) [Metzner et al., 2016].

To a limited extent, specialised treatment centres, which partly treat refugees in need of psychological care regardless of their insurance status, are available in Germany [Classen, 2011]. Within the Arbeitsgemeinschaft der Psychosozialen Zentren für Flüchtlinge und Folteropfer e.V. (Professional Association of Psychosocial Centres for Refugees and Torture Victims) (BAFF), founded in 1996, 37 treatment centres are listed, on whose waiting lists there is an average of 1,500 refugees each month such that, in some cases, admission freezes had to be implemented (33%) or individuals seeking treatment were simply rejected (47%) [Baron and Flory, 2015]. As the treatment centres are chiefly funded by grants from the European Refugee Fund and the Asylum, Migration and Integration Fund, they cannot cover the demand for psychotherapeutic treatment for refugees with their current structural and financial resources [Baron and Flory, 2015]. Psychotherapists active in an ambulatory setting who treat refugees with the aid of an interpreter are therefore increasingly important. As only very few psychotherapists in Germany offer treatment in languages such as

Arabic or Farsi, refugees must almost always be treated with the aid of an interpreter. Interpreter-aided PT (IPT) is a particular form of intercultural PT, in which adequate attention to the peculiarities of the triadic setting as an aspect of the therapist's intercultural competency [Schouler-Ocak and Aichberger, 2017; Storck et al., 2016] is a precondition for the successful treatment of refugees. So far, only a few psychotherapists have experience with PT as part of a triad with an interpreter.

Interpreters in a Psychotherapeutic Setting

Expectations of treatment as well as definitions of illness and health can vary from culture to culture. Most of these culturally formed ideas are not familiar to therapists and are seldom considered in the therapeutic approach [Schouler-Ocak and Aichberger, 2017]. Interpreters as linguistic and cultural mediators have the task of mediating not only on a linguistic level between therapist and patient, but also on a cultural one, resolving diverging concepts of illness and making mutual understanding possible [Dhawan, 1995; Kluge and Kassim, 2006].

Adding a third person leads to a fundamental change in the therapeutic setting and can be of a challenging nature. As such, difficulties in interpreting, the confusion of roles and complex transference and counter-transference phenomena must be taken into consideration by therapists [Storck et al., 2016].

Initial empirical investigations resulted in implications for the efficacy of interpreters in PT with refugees [Brune et al., 2011; d'Ardenne et al., 2007] and showed that interpreters were perceived to be of great help by the vast majority of patients (96%) [Hadziabdic et al., 2014].

In PT, interpreting is generally done consecutively, in other words, non-simultaneously. Amateur interpreters should be distinguished from professional interpreters, although often only amateur interpreters who – in contrast with professional interpreters – are not under oath and have not studied interpreting techniques at a university or vocational college are available for the languages of refugees. Interpreters often have no established knowledge of interpreting in a psychotherapeutic setting [Wolf and Özkan, 2012]. In the cases of inexperienced and non-professional interpreters, there is a heightened probability of incomplete and lacking translation, which is evident for example in the results of Flores' [2005] study, according to which 23–50% of the therapists' questions were either not translated or misunderstood by a non-professional interpreter. In 90% of ambulatory practices and facilities, non-professional interpreters are employed, above all due to the unresolved cost takeover [Odening et al., 2013].

Funding of Interpreters in PT

Although the stipulations of the ASBA support a cost takeover for interpreters in therapeutic settings, the cost of interpreters must often be carried by psychotherapists or patients themselves [Penka et al., 2012]. Government social security agencies, public health officers and courts place very high demands on the cost takeover, underestimate language difficulties or instead recommend treatment with medication [Classen, 2011]. As German has been set as the

administrative language with sign language being the only exception, interpreting benefits are not offered as part of SHI and, as such, the costs are not covered after an initial stay of 15 months [Metzner et al., 2016]. Along with the high formal costs, the unresolved takeover of interpreting costs is the main hindrance to psychiatric and psychotherapeutic care for refugees [Metzner et al., 2016; Mewes et al., 2016].

Training of Therapists and Interpreters for IPT

In Germany, psychotherapists and interpreters are not, as a rule, trained for IPT, and there is a lack of unified standards for training in IPT [Salman, 2001]. Therapy institutions which frequently work with interpreters have developed training concepts or guidelines for IPT, in which recommendations for the structural framework of IPT are made on the basis of some experience, e.g., for the structure of a therapy session or the billing of interpreting expenses [IN TERRA – Psychosoziales Zentrum für Flüchtlinge, 2015]. Coming from such countries as the Netherlands, UK, Canada and Australia, where linguistic diversity is already socially and legally more established than in Germany, standards for working with interpreters in a social-psychiatric or psychotherapeutic setting are available, which address the seating arrangement, mode of speaking, briefing and debriefing, as well as the contacting and utilisation of interpreting services [Miletic et al., 2006; Salman, 2001; The British Psychological Society, 2008]. Holistic reports which consider the experience of the full triad of therapist, interpreter and patient, and which are based on empirical studies, can hardly be found at this time.

Due to the lack of experience with and standards for IPT in Germany, insecurities and fears are present among both therapists and interpreters concerning the structure, organisation and effectiveness of triadic therapy. The high number of refugees, however, constitutes a good reason for paying more scientific attention to IPT. As such, it has been our aim to conduct a pilot study on the prospects and challenges of IPT from the perspective of therapists (Study 1) and interpreters (Study 2) by means of guided interviews and, thereby, to qualitatively extract experience in triadic work.

Qualitative Studies on the Assessment of Therapist and Interpreter Perspectives

In order to capture the experience of the psychotherapist working within the triad in all its breadth and complexity, as comprehensively, multifariously and as closely to reality as possible, a qualitative study design was selected for both studies. As we were less concerned with falsifying existing results due to our aim of conducting a pilot study, and more with achieving new insights through examining the reality of the interview subjects [Mayring, 2002] by means of personal inquiry of therapists and interpreters within the triad, the sample size was limited to 5 therapists and 3 interpreters.

Study 1: Psychotherapists' Perspectives

Method

Implementation and Instruments

Open and semi-structured guided interviews were conducted with 5 psychotherapists from northern Germany. One criterion for the selection of interview partners (IPs) was that the therapist must have already had experience in working together with interpreters in PT with refugees. Participation in the interviews, which were between 60 and 120 min in duration, was voluntary and not remunerated. The problem-centred interview as per Witzel [2000] was chosen as the interview style, with a focus on a predetermined and pre-analysed, socially significant problem. Relevant themes which were to be addressed during the interview were assembled into a loose guide, not having been heavily formulated or detailed in order to allow for a flexible and open interview and to preserve the open and half-structured character of the interview.

As, due to the specificity of our line of questioning, we were not able to draw on any existing interview template, we designed a template ourselves. By means of a literary research using the Google Scholar database, Medline, PSYINDEX and PsycINFO, we identified influencing factors of IPT and formulated them as interview questions. In the interviews, the aspects of role allocation [Morina et al., 2010; Orth, 2001; Ruf-Leuschner et al., 2015], interpreting technique [Brune and Akbayir, 2008; Miletic et al., 2006], education and training [Miller et al., 2005; Morina et al., 2010] and interpreter-patient compatibility [Abdallah-Steinkopff, 1999; Brune and Akbayir, 2008; Hadziabdic et al., 2014] were explicitly addressed. The template structure was designed based on the core elements of open and half-structured problem-focused interviews as per Mayring [2002] (probing questions, guideline questions and ad-hoc questions). As a concrete entry to the interview, the question 'How have you come to be doing interpreter-aided psychotherapy?' constituted the stimulus for generating an information flow. Next, we asked about personal interest in the topic and peculiarities in working with refugees. The focus of the interviews was on the experienced prospects, challenges, possible standards and recommendations of psychotherapists for triadic PT. To conclude the interview, psychotherapists were given the opportunity to name any relevant issues which had not entered the conversation to that point. The openness of the interview style allowed IPs room to move in order to vocalise the reality of their own experience and allowed the interviewer to pose spontaneous, appropriate and more in-depth (ad-hoc) questions [Mayring, 2002].

Sample Composition

The 5 interviewed psychotherapists (n = 4 female) were aged between 37 and 61 years, had between 3 and 25 years of experience with triadic work and worked chiefly with adult patients (n = 1 with additional qualifications for working with children). Three of the psychotherapists were trained in deep psychology, while 1 psychotherapist worked based on behavioural therapy and 1 on conversational therapy. Three psychotherapists were active in an established practise and 2 in ambulances of one clinic. Two IP had a migrant background, of 2nd and 3rd generation, respectively.

Evaluation and Quality Criteria

The interviews were drafted digitally, transcribed as per the simple transcription system of Dresing and Pehl [2011] and finally presented to the IP for communicative validation [Mayring, 2010]. The data gained in interviews were evaluated by means of the qualitative content analysis method as per Mayring [2010], such that a system of categories was developed with main categories and subcategories. As our analysis technique, we chose summarisation. By means of central interpretation rules (CIR), the given material was reduced to essential meaning, checked in terms of topical coherence through abstraction and grouping, and organised into a system of categories with overarching topics (main categories) and more specific aspects (subcategories). The aspects in the interview template which were derived from the literature (role allocation, interpreting technique, interpreter training and education, interpreter-patient compatibility) were incorporated as main categories and subcategories, meaning that

we implemented not a purely inductive approach but, rather, also partly a deductive one. To confirm whether the category system was representative of the raw data, an independent party reviewed and analysed the raw material. The quality criteria of the procedure documentation, the compliance and the reliability within and across codes for qualitative research were met.

Results

By use of content analytic evaluation, we were able to explore the following 8 main categories: a) outer circumstances, b) choice of interpreter, c) interpreting technique, d) role of the interpreter, e) role of the psychotherapist, f) relationships within the triad, g) impacts on the emotional experience and h) the rhythm of communication.

a) Outer Circumstances

The interviewed psychotherapists described the meaning of language in PT as follows: 'As soon as I've mastered a language well enough that I can establish a close human relationship in this language, a close friendship or a romantic relationship, then I will be able to give therapy in this language, too' (IP2). With respect to the lack of native speakers, they emphasised the necessity of conducting PT with the support of interpreters. Offers of clinical supervision for interpreters and therapists, as well as regular briefings and debriefings were named as core aspects of effective work with interpreters. While briefing sessions were used by therapists to instruct interpreters and prepare them for planned therapeutic interventions, debriefings allowed for interpreters to be spoken with about any burdening issues in order to reduce the risk of secondary trauma, or for a comparison of perspectives on the therapy session: 'If I can at least briefly have an exchange with the interpreter afterwards and hear about her view on the case, that is rewarding, I find' (IP5).

The unresolved funding of Interpreters was described by all 5 interviewed therapists as one of the greatest challenges in IPT, because, due to the unclear regulations, it requires great expenditure. The funding of professional interpreters was often not achieved, meaning that amateur interpreters had to be employed: 'Those who interpret professionally or have studied interpreting generally cost more [...] any measure ultimately has to be economically feasible and I think it's utopian to think that we should have to pay even more for interpreters' (IP3). However, therapists advised against the use of relatives as interpreters in PT: 'Naturally, as with any therapy, if someone is married or living in a de facto relationship, I will ask: "How is your marriage going?" In this case, the husband can of course not be the Interpreter' (IP2). Generally, they had worked with amateur interpreters and expressed the need for interpreter pools with specialised interpreters trained in PT: 'Education and training is, for me, one of the key phrases. With these, one is more professionally associated' (IP4). The IP recommended training in which psychotherapists were trained for work with interpreters in order to reduce inhibitions and restrictions: 'I believe it's important to foster an attitude that one doesn't have to be afraid. For many of my colleagues who seldom work with interpreters it's often a big question mark [...]' (IP3). Three of the 5 therapists felt that specialised therapy centres for the treatment of refugees suffer-

ing trauma would be useful: 'Centres which specialise in this – that's much easier. They always have people there, and they're certainly more accustomed to work with interpreters' (IP1).

b) Choice of Interpreter

The therapists reported that interpreters who had been refugees themselves had a greater level of access to the patients than did the therapists: 'And the [interpreter] is in a way more connected with that, too, or can understand it, the pain. There's no way I can provide that' (IP4). When selecting an interpreter for PT, the therapists took care that the interpreters had worked through their own trauma. Alongside the biography of the interpreters, their cultural background also played an important role for the therapists. The interpreters' background knowledge about the patient's culture was found by all IPs to be helpful. Interpreters coming from the patient's country of origin were seen as cultural representatives and persons of confidence who provided patients with feelings of security and support: 'They've been completely uprooted, and it has an immense meaning meeting someone who speaks the language, who knows the country and who knows where they come from' (IP2).

The therapists did observe, however, when using interpreters who came from the same culture as the patient, that this sometimes had the opposite effect in the form of distrust, e.g., if patients had experienced violence at the hands of compatriots and in turn associated the interpreter with their experiences: 'And sometimes there's also a political back-story. For example, in the case of Kurdish people, if we're working with Turkish-Kurdish interpreters, it gets difficult. Also with people who've experienced a lot of political persecution or have been pursued and don't really know "can I trust him or not?"' (IP4).

c) Interpreting Techniques

All therapists emphasised the importance of complete and precise interpretation in order to avoid the loss of information important for the therapy and to avoid distrust. Four of the 5 therapists placed value on everything which was said in the room being translated: 'Or I speak and pose a question, and then the patient speaks for 10 minutes, and then I get a one-sentence answer translated. Something's not right there' (IP2). All therapists interviewed required first-person interpreting. IP2: 'If the patient says "I would like to ask you a question", then the interpreter says "I would like to ask you a question". He shouldn't say "The patient would like to ask a question".'

d) Role of the Interpreter

All 5 therapists spoke about the importance of clear role allocation within the intercultural triad. The interpreter, according to the therapists, has the role of the empathetic, verbatim translator. Independent intervention by the interpreter can, in their judgment, lead to incomplete or inaccurate translation and, through the loss of important information for the therapy, influence the therapeutic process: 'When I say to the patient "What kind of relationship did you have to your father?" and the patient says "My mother was al-

ways very kind to me” and the interpreter says “No, the therapist didn’t ask about your mother, he asked about your father” and then we hear again “My mother was always very kind to me” and then the patient only says after the interpreter’s third attempt at clarifying “My father was a nice man”, then that would be important diagnostic/therapeutic information that is lost to me’ (IP2). In order to maintain a clear role division within the triad, the therapists ruled out any contact between the interpreter and the patient outside the therapy setting. Alongside the most literal interpretation possible, all IPs perceived the mediation of language and culture between therapist and patient as a key task of the interpreter. As therapists often lack knowledge about the language and culture of the patient, the interpreter can serve as a direct source of information in order to provide background cultural and linguistic information: ‘I always found it helpful to ask them “What does that mean?” Also relating to cultural background or linguistic things, for example’ (IP3). Two IPs mentioned the role of the interpreter as a role model for the patient: ‘[The interpreter] is a person who is obviously managed well, who has a respectful and friendly relationship with the doctor and, in this way, they also set an example. So, you can make it here in this country’ (IP2).

e) Role of the Therapist

All IPs saw themselves as chiefly responsible for the therapeutic process. For them, the clarity and transparency of the role division for everyone involved in the triadic PT was particularly important to avoid confusion of roles, misunderstandings and personal involvement: ‘When the roles are defined and then spontaneously change – sometimes this way, sometimes that – that’s bad for the therapeutic consultation [...] because the patient sometimes says: “You’re not allowed to tell the therapist, what I just said”’ (IP2).

f) Relationships within the Triad

In the experience of the interviewed therapists, the cultural and linguistic closeness of the interpreter to the patient made establishing the relationship between therapist and patient more difficult: ‘And of course there are patients who relate closely to the interpreter, which then makes it difficult to a degree to establish a relationship in this way as you normally would, that between the therapist and the patient’ (IP3). According to one therapist working in depth psychology, complex transference and countertransference reactions resulted, for example in the form of alliances. Interpreter and patient may accuse the therapist of being responsible for a possible lack of progress in therapy. However, this was not seen as a disadvantage but rather as a source of relevant information for therapy: ‘Yes, if you pay good attention to such alliances, which play out very subtly, that can provide interesting information’ (IP2). A trusting and fitting patient-interpreter relationship, according to therapists, increased the willingness of patients to engage with the therapeutic process. The interviewed therapists saw the mutual confidence of all involved as a precondition for the success of triadic PT: ‘So trust between all three individuals present must be there so that one may also share the most intimate things, that which has injured one the most in life so far’ (IP2). As a sig-

nificant precondition for an atmosphere of trust within the triadic setting, the continuity of the participating persons was also mentioned.

g) Impacts on the Emotional Experience of the Therapist

The presence of an interpreter in psychotherapeutic sessions was experienced by the IPs as emotionally supportive. Through the triad, they were able to gather experience in a sustainable and stable atmosphere within the PT: ‘I’m very grateful whenever the interpreter is simply present in the room. That alone makes a big difference. And I find, that’s really supportive to the therapeutic process’ (IP4). Due to the linguistic and cultural closeness of interpreter and patient, the triadic setting sometimes led to the therapist feeling as in a sort of external role: ‘In the beginning, I also found it really strange and felt so sidelined as the therapist and also partly had a feeling of rejection or of being rejected’ (IP3). For the therapists, the feeling of being under observation or of giving up control to the interpreter was unsettling: ‘It’s a difficult dynamic. You’re responsible, but at the same time you have to surrender something. That is, I also have to have confidence in the interpreter, otherwise it doesn’t work’ (IP5). Insecurity was experienced by the IPs chiefly in the beginning of their work with interpreters and lessened with increasing experience: ‘And the more and the longer I had worked with interpreters and the more I thought about it, the better I’ve been able to work with interpreters’ (IP2).

h) Rhythm of Communication

The interpreting led, in the experience of the interviewed therapists, to a slowing down of the therapeutic process as well as to a loss of spontaneity. The therapists reported that they could not spontaneously intervene or react to the patients emotions when they needed to wait for the interpreter’s translation; but this delay also allowed them time to reflect, to observe non-verbal behaviours and to empathise: ‘This is also very important, to simply observe well and to observe in a focused manner, how tense are they, how is their expression, is their posture lively or more stiff, and one can perhaps observe such things even better when one has time for it, because the others are talking with each other right now and you’re just watching for the moment’ (IP3).

Study 2: Interpreters’ Perspectives

Method

Implementation and Instruments

For the exploration of cultural and biographical factors influencing the psychotherapeutic triad from the interpreters’ point of view, we conducted semi-structured cue-question interviews with 3 interpreters from Northern Germany. The study was explained to the IPs, and they received a remuneration of EUR 30. The interviews were between 45 and 60 min in duration.

The questions in the qualitative interviews were developed based on the literary research into IPT for refugees suffering trauma using the Medline, PSYINDEX and PsycINFO databases. The factors of role and understanding of oneself [Abdallah-Steinkopff, 1999; Kluge, 2011; Searight and Searight, 2009], ethnicity, political alignment and religious persuasion [Abdallah-Steinkopff,

1999; Morina et al., 2010] as well as personal trauma [d'Ardenne et al., 2007; Fessler and von der Lippe, 2013] were identified. The interview template was divided into 4 sections: Entry, Interpreting, Biographical and Cultural Influencing Factors and Conclusion. In the last section of the interview, IPs were given the opportunity to mention issues and concerns which had not yet been addressed in the conversation to that point.

Sample

Three interpreters (n = 2 female) aged 34 to 50 years from Guinea, Israel and Somalia, who were primarily active interpreting in PT with refugee children and adolescents, were interviewed. Their professional experience amounted to between 5 and 8 years each, though none of the interpreters possessed a vocational qualification specific to the work. The IPs interpreted the French, Farsi, Hebrew, Arabic, Somali and Fula languages.

Evaluation and Quality Criteria

The interviews were assessed separately for each IP by means of structuring content analysis. This was done using a deductive implementation of categories [Mayring and Fenzl, 2014]. The interviews were analysed in terms of the following 3 categories: a) biography, understanding of roles and personal concern, b) cultural challenges and c) structural circumstances, which were weighted and valued differently by each interviewed interpreter. The quality criteria of the guideline documentation and cross-code reliability for qualitative research were met.

Results

For the 3 main categories, the following subcategories were identified for the interviews: 1) biographical factors: education, professional development, motivation, feelings/concern, understanding of self/role, insecurities, patient contact, desires; 2) cultural factors: cultural challenges: general, gender and taboo topics; 3) structural factors: guidelines and regulations, peculiarities within the psychotherapeutic triad, method and supervision.

a) Biography, Understanding of Roles and Personal Concern

None of the IPs possessed a field-specific qualification for interpreting. They described interpreting in the psychotherapeutic triad as a 'sidestep' (IP1), in which they had 'gathered experience through the work' (IP1) or through other vocational training. All interpreters had completed qualifications in other fields and simultaneously begun interpreting: 'I started at the Immigration Office in initial receptions [...] and there I did it a few times and then I just kind of fell into it' (IP3). As their motivation, the IPs mentioned monetary incentives (IP2), but also the desire to help and to do something meaningful: 'This is my way of giving support' (IP3).

All IPs reported a strong sense of being personally affected by the biographies of the patients such that some of them observed a confusion of roles on their own part: 'And sometimes they have me so involved with what they've experienced [...] and I think I've taken on the role which the adolescent I'm translating for should really be playing' (IP3). All interpreters told of patients who evoked strong negative reactions within them and who still occupied their minds well outside of work. The interviewed interpreters spoke of the desire to be seen within the PT not only in their role but also as human beings: 'I'm not a machine, I'm not a device which interprets' (IP2). The desire for educational and training opportunities for interpreters, for autonomy and for recognition of their work as interpreters was also expressed.

Insecurities were present for all IPs regarding professional conduct within the triad, e.g., in the case of contrary statements from patients: 'Therapist, patient and me, there's always something funny going on' (IP2). One of the 3 interviewed interpreters reported having had patient contact outside of therapy within a leisure activity setting.

b) Cultural Challenges

The IPs listed distrust and misunderstanding of interpreters, therapists or the PT on the part of patients as culturally challenging: 'So we partly work with adolescents who didn't go to school, and when, for example, you say "self-esteem" in Arabic, then they say "I've never heard of that" and then you have to explain it' (IP2). While 2 IPs had experienced no difficulties related to the gender of patients or therapists, IP1 noted: 'Most of the time, girls have the same story, for example, a big word: rape. Of course, then it's better if only women are present, for example. I assume it's not necessarily unacceptable only for cultural reasons.' The interviewed interpreters stated that they did not feel limited in PT by cultural taboos but that they had occasionally observed cultural taboos in patients, for example when they 'won't [say] exactly what happened' (IP3).

c) Structural Circumstances

The IPs reported consistently that they were adhering to confidentiality but knew of no binding regulations around this: 'Well, you learn with time, but there are no real guidelines. You can't really say that there are, because in psychiatry or here, when we work with psychologists, it's just so different' (IP2). While 2 of the 3 interpreters interpreted using the first person, 1 IP used the third person, because interpreting in the first person felt 'somehow uncomfortable' (IP3).

Interpreting within the psychotherapeutic triad was experienced as very demanding by the IPs due to, among other things, the concentration required, the therapeutic interventions and the technical terminology needing to be translated. IPs named the meaningfulness of their role as one of the positive aspects of interpreting: 'Here, we see how the boys are able to deal with what they've experienced, you get the feeling all of this helps them. I have the feeling that it helps me, too' (IP1).

Support for interpreters within the framework of supervision was, in the experience of the IPs, either not given often enough or, after many years of interpreting, was unknown to them: 'I didn't even know there's such a thing as supervision. That would really help me a lot' (IP2).

Summary and Discussion

While a large part of the literature on IPT with refugees described the challenges for therapists and patients or the role of and difficulties for interpreters [Morina et al., 2010], the 2 interview studies conducted so far have identified barely known aspects, which also include the interpreters' perspectives (Table 1).

Table 1. Treatment recommendations for the triad of patient, Ip and Pt

	Recommendations
Structural recommendations	<ul style="list-style-type: none"> create an adequate offer of supervisions for Ip and Pt avoid relatives as Ip, establish the use of professional Ips offer training on the intercultural setting and IPT for Ip and Pt establish Ip-Pools establish specialised therapy centres regulated funding of the costs for interpreting
Recommendations for the Pt in follow-up discussions	<ul style="list-style-type: none"> responsible for the therapeutic process create clarity and transparency regarding the allocation of roles towards patient and Ip integrate the cultural background knowledge of the Ip in follow-up discussions, respect the Ip's perspective of the therapeutic process clarify culturally-based distrust between Ip and patient use the translation process to reflect, observe and emphasise accept insecurities, give yourself time to grow accustomed to the triad
Recommendations for the Ip	<ul style="list-style-type: none"> no own traumatisations unless already processed complete and precise translation in an empathic manner give translation in the first person as a cultural and linguistic mediator, refer to linguistic and cultural peculiarities avoid any contact between you and the patient outside of the therapy setting continuous attendance during the whole therapeutic process
Recommendations for the Pt and Ip	<ul style="list-style-type: none"> development of a harmonious and trustful relationship

Ip = interpreter; Pt = psychotherapist.

The funding of interpreting services was mentioned by all interviewed psychotherapists as a key challenge. In this way, the IPs were consistent with the psychotherapists surveyed by Mewes et al. [2016], who labled the unresolved cost takeover as one of the most important aspects for the improvement of care for refugees in Germany. As shown by Odening et al. [2013] and Wolf and Özkan [2012], the interviewed psychotherapists pointed to the lack of availability of professional interpreters. Though assigning relatives or acquaintances of patients for interpreting was strictly ruled out by all psychotherapists interviewed for this research, they frequently worked with non-professional interpreters due to a lack of training options for interpreters regarding the psychotherapeutic setting and because the unresolved cost takeover made the access to professional interpreters difficult. Working with non-professional interpreters bears the risk of confusion of roles and translation difficulties. It is uncertain whether the interpreters are really interpreting what they are supposed to and whether they are maintaining interpreting ethics. Here, the relevance of crossing boundaries in the form of independent intervention by interpreters has not been clarified. Qualified interpreters and those experienced in PT know how and what they are supposed to interpret. The therapists recommended the establishment of interpreter pools specifically for the therapeutic setting and of therapy centres where interpreters and psychotherapists trained for working with refugees suffering from trauma are active. The psychosocial centres already organised under the umbrella of the BAfF may serve as an example, here.

The interpreters interviewed in this study consistently valued the demanding work within the psychotherapeutic setting with refugees as being important and meaningful. The psychotherapists surveyed, who had much experience in IPT with refugees, also per-

ceived the presence of an interpreter as valuable and necessary support from a cultural and linguistic mediator, as interpreters can serve as a direct source of information about linguistic and cultural peculiarities. In this way, they pose a counterweight to the observations of Morina et al. [2010] according to which numerous psychotherapists rejected IPT or had great reservations concerning interpreters. However, the psychotherapists interviewed in our study also reported that it was only through increased experience, which develops sustainable and trusting relationships within the triad of patient, interpreter and therapist, that they have gained confidence in working with interpreters. In contrast with authors such as Morina et al. [2010] or Abdallah-Steinkopff [1999], who focused more on the interpreter-patient relationship, the interviewed psychotherapists particularly emphasised that a relationship of trust based on sympathetic feelings must be present in order to avoid distrust and conflict. The interpreters not possessing a qualification were in part very concerned about dealing with patients and psychotherapists due to the lack of standards and training opportunities for the psychotherapeutic setting which go beyond teaching verbatim interpreting and confidentiality as well as the often lacking support from psychotherapists. Interpreters and psychotherapists alike brought up the issue of the lack of adequate supervision offers for interpreters and therapists, training for the interpreter-aided setting for interpreters and therapists, and regular briefings and debriefings. Briefings constitute an adequate preparation for the therapeutic setting. Debriefings offer the interpreters the chance to speak about their emotional concerns and to unburden themselves to avoid secondary trauma. Psychotherapists have the opportunity to integrate the perspective of the interpreter as part of the debriefing and, hence, to view the therapy session from another angle. Regarding possible training offers, preparation is not only important

for the triadic setting but also for the intercultural setting in order to sensitise psychotherapists and interpreters to the significance of culture in PT [Schouler-Ocak et al., 2015].

When assessing the results of the 2 interview studies, it must be considered that the psychotherapists and interpreters who are active within the framework of the triad represent a heterogeneous group with different backgrounds and cultural identities and that the results are – due to the small sample size – of a pioneering nature and should be validated using a larger sample. The 2 studies presented here can therefore only provide an extract of attitudes and experiences. The qualitative approach did, however, enable the IPs to comprehensively express their views on IPT with refugees. Mewes et al. [2016] emphasised the significance of reports on experiences with IPT in order to carry out important clarification work. The present study allows psychotherapists and interpreters insights into IPT and as such can contribute to an increase in psychothera-

pists' readiness to treat refugees with the support of interpreters, whose preparedness has up to now been middling [Mewes et al., 2016]. To this point, it can be deduced from the 2 studies conducted that regulated funding of interpreting costs, supervision and training offers for interpreters and psychotherapists, regular briefings and debriefings, mandatory standards and guidelines, gathering of experience, continuous triadic setups, clear role division in the triad, established interpreter pools and specialised therapy centres are possible factors for the success of IPT with refugees. As the field of IPT for refugees has barely been empirically researched so far, the results of the 2 studies presented here may serve as a starting point for further qualitative and quantitative research.

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