Working with Interpreters: Clinical Implications for Couple and Family Therapists

Jeffrey McCrossin, C.F.T., S.W., Psychotherapist, Ph.D.(c), McGill University
jeffrey.mccrossin@mail.mcgill.ca
Maude Champagne, T.S.I., Psychotherapist, Ph.D.(c), Ottawa Center for Attachment and Trauma Therapy
20mc17@queensu.ca

ABSTRACT:

Ethically, Couple and Family Therapists (CFTs) must not refuse service on the basis of language barriers, necessitating the engagement of language and culture interpreters. As they are trained in systemic approaches and accustomed to working with multiple persons in a therapeutic space, one might assume CFTs are naturally adept at working with interpreters. However, surprisingly little has been written about methods, roles and evidence surrounding cultural and language interpretation in the field of couple and family therapy. In this narrative review article, we summarize the limited literature available on language and culture interpretation in couple and family therapy and draw on the broader field of mental health to explore issues including interpreter-therapist-client alliances, therapist and interpreter training and practical considerations through a systemic and anti-oppressive practice lens. We put forward our suggestions of how to engage interpreters in the context of couple and family therapy.

KEYWORDS:

Couple and family therapy, interpretation, translation, culture broker

INTRODUCTION

Language and cultural interpretation is an essential component of health and social services, particularly for refugee and immigrant populations (Fennig & Denov, 2020). Couple and family therapists (CFTs) and other healthcare providers have an ethical and, in some jurisdictions, a legal obligation to ensure that clients[1] are not refused equal access to services based on language barriers (Gangamma & Shipman, 2017; Raval, 1996; Searight & Armock, 2013). However, integrating interpretation services into Couple and Family Therapy (CFT) is a complex process that requires careful consideration. While some guidelines for general mental health interpretation exist (e.g., Leanza & al., 2014; Miletic & al., 2006), CFTs and the interpreters who work alongside them are left with the challenge of adjusting these strategies to their unique practice environments.

Through a narrative review of the literature, this article describes the various roles that interpreters can play in CFT beyond basic translation. A summary of proposed practice guidelines drawn from the literature are presented as applicable to CFT from an anti-oppressive practice lens, including

1. For the sake of simplicity, we refer to individuals, couples, and families as the client, unless otherwise specified.

when interpreters should be brought into therapy; how interpreters can facilitate mental health treatment; and basic structure to support a healthy therapist-interpreter relationship. Finally, challenges in therapist-interpreter-client relationships, as well as unique opportunities for interventions are discussed.

1. Methods

We initially searched several allied health databases including CINAHL, Web of Science and PsychINFO using search terms related to couple and family therapy and interpretation with the specific goal of identifying guidelines for CFTs on working with interpreters. Terms were matched to subject headings, where possible, according to the database and were also searched as keywords. The search terms we used that related to couple and family therapy varied by database but generally included marriage and family therapy, family intervention and family conflict. Search terms related to interpretation also included those related to translation. For the purposes of our narrative review, articles on interpretation for deaf or hard-of-hearing persons were excluded, as guidelines for oral languages tend to differ from sign language (de Bruin, 2006). Following a scan of titles and abstracts, we were unable to identify specific guidelines for CFTs. As such, we shifted our focus to identify works that could inform CFTs on key considerations when working with interpreters. We supplemented our search with Google Scholar for journal articles and book chapters using similar search terms. Furthermore, we searched reference lists and leading CFT journals for titles related to interpretation. Since our initial interest in exploring this literature was driven by clinical necessity rather than research, our review is admittedly narrative and subjective, rather than systematic. Further to this point, we did not set out intentionally in this project, designing our search protocol and inclusion/exclusion criteria in advance and tracking our process (e.g., meticulously logging the number of relevant abstracts, articles and chapters) as one would typically expect in a systematic review. Instead, the narrative review we present here is based on a post-hoc process of organizing the pieces of literature we found, in our opinion, to be most clinically relevant. We discuss the significant limitations of this review further in our conclusion but hope that readers (clinicians and researchers alike) will find this review to be a practical starting point to become familiar with many key issues related to practicing couple and family therapy with an interpreter.

We relied on our experience as clinicians (and as former trainees) to extract what we felt was most useful for clinical practice with couples and families in sessions with interpreters. Content of interest evolved through an iterative process as the authors developed a better understanding of the available literature. Since we were seeking practice guidelines, our initial interest was focused on how to practice CFT in the presence of an interpreter. However, we found that much of the literature also spoke to issues of professional identity and training, power differentials, and related ethical issues. We chose to organize these themes in the results section below around building therapist-interpreter teams; considerations for CFTs on how to begin working with interpreters and key issues that may arise during this initial phase of practice development; followed by challenges and advantages of practicing couple and family therapy with an interpreter.

2. Results

The majority of the literature reviewed did not specifically focus on CFT, but instead provided guidance for general mental health intervention with interpreters (i.e., individually based psychotherapy or psychosocial support). We contextualized these lessons from the literature to issues and themes we believe to be most relevant to CFTs.

2.1 Building Therapist-Interpreter Teams

Considerations of Culture and Power

Considerable power differentials are often at play in relationships between therapists, interpreters and clients. In contrast to interpreters, therapists are typically the leaders in the therapeutic space: they set the framework and pace based on the client's concerns or goals. Interpreters are usually expected to follow the therapist's lead by sticking closely to the script, which sheds considerable light on the obvious hierarchy in the room. Furthermore, there might be a power imbalance stemming from the first language and cultural heritage of the therapist who may hold considerable social power over both the interpreter and the client who are often members of minority cultures (Becher & Wieling, 2015). While clients may view therapists as experts, they may not perceive interpreters in the same light, even if they have been professionally trained. In addition to potentially experiencing marginalization because of their culture, clients and interpreters may also experience various forms of oppression based on language, country of origin, race, and socioeconomic and immigration status. Interpreters are usually paid less, have less job security, less education, less respect within institutions and are less likely to have their services covered by insurance than therapists (Becher & Wieling, 2015). An exploration of the intersectionality of therapists', interpreters' and clients' various identities and group memberships and the cumulative impact of oppression experienced by each person can greatly contribute to the therapist's framework for understanding the family's needs and experiences (Gangamma & Shipman, 2017; Larson, 2008). In light of these concerns, it is necessary for this triadic relationship to be collaborative and dynamic rather than hierarchical (Kirmayer & al., 2003; Paone & Malott, 2008; Tribe & Lane, 2009; Tribe & Raval, 2003).

By engaging in social justice issues alongside therapy, mental health services can begin to deconstruct their power, engage in non-hierarchical partnerships with interpreters and support clients' self-determination (Waldegrave, 2009). For example, the Just Therapy group in New Zealand reported an expansion of their services from providing only family therapy to engaging in their community in other meaningful ways. Their initiatives included building cultural capacity through employing staff members that were representative of a range of cultures reflecting the population they served; engaging in social policy research and community development; and focusing on shared values as nomenclature for assessment and treatment as an alternative to the medicalization of mental health and illness. They explained this transition in their service was triggered by a realization that they were "unwittingly adjusting people to poverty or other forms of injustice by addressing their symptoms, without affecting broader social and structural change" (Campbell & al., 2012, p. 198).

A successful interpreter-therapist partnership requires a systemic understanding of the roles and relationships of these professions in relation to the client. From a systemic perspective, interpreters can be understood as partners within the family system, much like the therapist or other members of a multidisciplinary team. However, interpreters are also necessarily members of the treatment team representing health care services and often act as a culture broker between the client and the therapist.

What do Interpreters do? The Complex Role of Interpreters in Therapy

The role of the interpreter is much more significant than that of a word-for-word translator. Instead, interpretation "advances meaning in the fullest linguistic and cultural sense, so that two people are able to understand each other beyond their words" (Tribe & Raval, 2003, p. 16). Interpreters can play various roles, ranging from adding cultural context to the words they translate to being a full co-therapist who is reflective, aware of their biases, understands well the goals of the therapy and can

be a partner in guiding clients toward reaching their objectives (Leanza & al., 2014). Interpretation enhances service delivery through a better understanding of the client in relation to language but also cultural nuances, idioms and beliefs about health and wellness (Tribe & Thompson, 2011).

Complex emotions may be more difficult to translate as they may depend on the cultural context of social situations, which could differ even within families, especially in the context of immigration and varied levels of acculturation to the host country (Leanza & al., 2014). Interpreters are responsible for interpreting all transactions, including any cross talk, between clients and therapists and in the case of bilingual families, between clients themselves (Ali, 2004). For example, in a family where parents have only basic English language skills while the children are fluent, the interpreter will need to interpret any discussion that occurs in English between the children back to the parents, and help them understand any cultural relevance (Darling, 2004). Furthermore, the therapist-interpreter team needs to be aware of the developmental level of the language being used as well as intergenerational differences in communication.

Interpreting for a couple or family increases the interpreter's workload. For therapists accustomed to less structured sessions, data collection becomes a much more challenging process. A collaborative agreement about how to process can be helpful to both team members. Interpreters and therapists may agree to interpret by short sequence of conversation or interaction, rather than attempting to interpret for several people simultaneously (Searight & Searight, 2009). In some circumstances, the therapist-interpreter team will decide to gather data on the content of the family's concerns through a summary interpretation (e.g., a short argument between family members), while in other moments they will proceed in a more organized and directed manner with phrase-by-phrase interpretation.

Multiple levels of interpretation are required in CFT. The therapist-interpreter team works together to interpret the language within the context of the culture and couple or family dynamics, and to develop a shared understanding of the meaning of behaviours and interactions of the members of the family system. For example, understanding the meaning behind a child's play may require the interpreter's expertise to share the meaning of words used by the child and possible cultural relevance of themes of the play. Meanwhile, the therapist's expertise permits possible interpretations of that play within the context of the family system and will reserve the decision about the usefulness and timing of sharing the interpretation with the parents (Darling, 2004).

Interpreting Culture

CFTs must examine the culture in which the employed assessment and treatment strategy was developed and consider whether it is appropriate for use with the client (Celano & Kaslow, 2000). Even with the help of a language interpreter, certain therapeutic approaches may not translate well across languages and cultures. Patterns that are commonly considered dysfunctional in families—such as parentification of children, triangulation and intergenerational coalitions—may be adaptive given a family's cultural reality and migratory experiences. Thus, the cultural context of apparently problematic patterns should be explored rather than presumed to be dysfunctional (Guzder, 2014). Culture can be considered fluid and negotiable as it changes in relation to generation, life experiences and immigration journey (Miklavcic & LeBlanc, 2014). Therapists may strive to be culturally sensitive, but at times may demand a cultural consultation to understand the nuances of how a client's current life circumstances (e.g., psychiatric symptoms) may be impacted by their culture (Guzder, 2014).

While not always in a position to do so, some interpreters may act as culture brokers as they are often tightly connected to the community or act as advocates and community workers (for a more nuanced discussion of the controversy surrounding overlap of these roles, see Leanza & al., 2017). Culture brokers provide the service of interpreting the cultural meaning of illness and can broker, negotiate or mediate a treatment plan that is culturally meaningful (Miklavcic & LeBlanc, 2014). This successful negotiation of culturally meaningful resources and support is a key process of family resilience (Ungar, 2010). Culture brokering is also a bidirectional process. For example, clients may seek the broker's understanding of the therapist's position on issues related to gender roles in regards to immigration processes in order to move forward safely in a conversation about their concerns (Miklavcic & LeBlanc, 2014).

Culture brokers support therapists to develop an understanding of the client's expression of distress through interpreting idioms and non-verbal communication, which may also be important for members of bicultural or intergenerational families that struggle to read one another's emotional expressions. In their mediating role, culture brokers "sensitize the clinical practitioner to the patient's system of belief and also helps the patient understand and trust the health care system or institution" (Miklavcic & LeBlanc, 2014, p. 120).

2.2 Working with Interpreters: Practice Considerations for Couple and Family Therapists

Initiating Interpretation Services in Therapy

Therapists first need to identify clients who may benefit from interpreter services and seek their consent to invite an interpreter to the session. Ideally, the invited interpreter will be a qualified professional with some training in interpreting for mental health services. There is some evidence to support choosing an interpreter who matches the client's demographics in terms of country of origin, language dialect, gender, age and religion (Tribe & Lane, 2009). In the case of CFT, this raises an obvious question: to which family member(s) should one attempt to match the interpreter? From an anti-oppression practice lens, the therapist would work collaboratively with the family to find an interpreter that feels safe for all members (Corneau & Stergiopoulos, 2012). Societal and cultural issues that may affect the relationship between the interpreter and family members should be explored (e.g., geopolitical conflicts, cultural issues related to gender) (Gangamma & Shipman, 2017). For returning clients, the same interpreter should be requested to minimize variables in the therapeutic process, particularly considering the complexity of triadic relationship dynamics (Raval, 1996).

Interpretation services should be offered to any client who does not speak the therapist's language. Some clients may refuse interpretation in an effort to project a sense of linguistic competence to balance power between themselves and the therapist, or within the family. For example, a father and husband of a family of five initiated family therapy. During the intake interview, he struggled with some English vocabulary. He indicated that English was his second language, but he was more comfortable speaking for himself and declined the offer to invite an interpreter to the first session. When the family arrived, the therapist discovered that the children spoke English fluently and had only basic skills in their parents' first language. Meanwhile, their mother spoke almost no English, leaving the father to hold the role of interpreter and mediator between family members. The therapist quickly discovered that the father regularly filtered messages between the children and their mother in an effort to avoid conflict in the home. How and when different languages are used in the family, including intentional efforts to guard secrets or unconscious

avoidance of intensely emotional content, is important data to be gathered, ideally through the collaborative efforts of both the interpreter and the therapist (Ali, 2004; Leanza & al., 2014; Searight & Searight, 2009).

It is clear that outside of emergent circumstances, the use of family members, volunteers or untrained staff as interpreters in clinical mental health assessment and treatment is inappropriate due to ethical and clinical reasons (Tribe & Lane, 2009). The use of any untrained interpreter risks errors in interpretation and exposure to traumatising histories (Paone & Malott, 2008). Furthermore, issues around confidentiality in such situations may put the client at risk. Using children or family members as interpreters risks developing or reinforcing emotional triangles and dissolving hierarchical boundaries (Celano & Kaslow, 2000). While engaging a family member as an interpreter for a family therapy session may spark clinically interesting questions (i.e., Who in the family is usually responsible for translating? Do they do a good job of this? Do they tend to withhold information?), such information could be gathered by simply asking these questions through a professional interpreter (Celano & Kaslow, 2000).

Interpreter Training

Interpreters' certification requirements vary significantly by country and region. In addition to translation skills, interpreters working in the field of mental health may benefit from training in ethics, mental health, traditional healing, loyalty issues toward therapists or clients and self-care (Tribe & Raval, 2003). As a part of best practice in cross-cultural family therapy, therapists are encouraged to examine the effect of their own culture on the therapy process (e.g., What are your family's beliefs that make up your culture? What groups will you have the easiest time working with?) (Celano & Kaslow, 2000; Hardy & Laszloffy, 1995; Leanza & al., 2014). Similarly, professional interpreters are encouraged to do the same, particularly when considering cultural conflicts that might negatively impact the therapeutic process (Raval, 1996). Interpreters may strive to maintain a neutral position but complete neutrality is just as lofty and unrealistic a goal for interpreters as it is for therapists (Guzder, 2014; Tribe & Raval, 2003).

Ideally, interpreters will have some knowledge and vocabulary related to the assessment tools or intervention being used by the therapist (Searight & Searight, 2009). This will facilitate the ease by which the interpreter will be able to transmit the desired messages from the therapist and elicit information in the manner intended by the therapist (Leanza & al., 2014). Training can also support the interpreter's understanding of the process of therapy, which can at times be counterintuitive and non-linear relative to other interpretation work they may engage in (Elkington & Talbot, 2016).

Interpretation and Trauma

Interpreters may have similar life experiences as their clients. This shared experience can facilitate interpreter-client rapport and support the interpreter to provide important contextual information to the therapist that may be relevant to the client's experience. However, clients sharing their experience can result in interpreters re-living their own trauma or experiencing vicarious trauma (D'Ardenne & al., 2007; Darling, 2004). When exposed to clients' traumatic histories, interpreters and therapists alike deserve opportunities for debriefing, reflection and supervision. Repression and emotional detachment are cited as strategies by some interpreters as a means of coping with the emotional intensity of trauma work (D'Ardenne & al., 2007). Recognizing and directly addressing the impact of this challenging work through clinical support such as supervision may be a more appropriate approach to reduce the risk of burnout within the therapist-interpreter team.

Therapists are routinely put in the position of providing support to interpreters in the form of debriefing following client disclosures of traumatic events (Dubus, 2015; Tribe & Raval, 2003). Searight & Searight (2009) encourage therapists to evaluate whether the interpreter appears to be experiencing a trauma reaction and decide whether they should be working with traumatized clients based on the level at which they have addressed their own trauma. In cases where prevention of exposure and reaction to trauma histories is not possible, the therapist can reflect on the interpreter's reactions to understand the client's experience. A client may recount their experience of trauma with emotional distance, while the interpreter experiences some emotional distress in receiving the story. The therapist can use the reaction to the story as a way of understanding the pain experienced by the client. The reaction can also serve as empathic validation for the client. This could be a particularly rich moment in family therapy for children who have been habituated to a parent's emotionally detached recounting of a trauma, and are now witnessing the interpreter's distressed response to the re-telling of a distressing event. This situation does, however, run the risk of turning the focus of the session away from the client and creating a situation more reminiscent of group rather than family therapy (Darling, 2004).

Developing the Therapist-Interpreter Relationship Before, During and After Sessions

In terms of best practice, the therapist-interpreter relationship is developed in three phases: pre-session briefing, within session interactions and post-session debriefing (Paone & Malott, 2008; Tribe & Lane, 2009). Tribe & Thompson (2011) recommend that therapists set aside about 20-30 minutes to account for pre- and post-session discussions. Therapists may also benefit from seeking specific training or supervision in relation to working with interpreters (Kirmayer & al., 2003). Prior to the first session, the therapist and the interpreter should discuss the following: the interpreter's understanding of the therapy process; the therapist's understanding of the interpretation process, confidentiality issues and regulations; culturally and therapeutically safe means of discussing targeted topics of inquiry for the session, as well as how to account for therapist and interpreter biases in relation to such topics; agreed upon roles and responsibilities (i.e., the therapist maintains clinical responsibility for the client); practical means of interpretation including where the interpreter will sit (e.g., triangle, circle or horseshoe formation so that all can benefit from reading the body language of others); and how to ensure the client understands the role differential and alliance between the interpreter and the therapist (Miletic & al., 2006). The pre-session discussion should aim to include a strategy for the interpreter to note and report (either during or after the session) when repetitive patterns with the client arise. The therapist-interpreter team can use the debrief discussion to develop a hypothesis as to whether such patterns are problematic or culturally appropriate, and whether they should be explored in future sessions.

During the session, the therapist speaks directly to the client while looking toward them rather than the interpreter. The role of the therapist-interpreter team should be clearly explained to the client including limits of confidentiality, clinical responsibility, and the extent to which the therapist and interpreter communicate outside of the presence of the client. The therapist should speak slowly and clearly, ask one question at a time, and frequently summarize session content to ensure a shared understanding. Speech should be simplified, avoiding idioms and technical language that may be challenging to accurately interpret (Tribe & Lane, 2009). The therapist should maintain a normal rate of speech, pausing every two or three sentences (but never mid-sentence) to allow for interpretation. In sessions with more than one client, the interpreter and therapist will need to clearly indicate to whom they are speaking and for whom they are interpreting. The therapist should create an environment where the interpreter is at ease with asking clarifying questions during the session (Tribe & Thompson, 2011). Any cross talk between the interpreter and client

should be interpreted for the benefit of the therapist, just as the client should be informed of any added cultural context shared by the interpreter during the session.

A post-session debrief allows for a conversation between the therapist and the interpreter to gather additional information that the interpreter may not have had the opportunity to share in the presence of the client. Having such conversations may risk negatively affecting the rapport between the client and the therapist or the client and the interpreter. For clients who have difficulties trusting the therapist, knowing that a discussion would follow the therapy session might feel uncomfortable to them. Transparency regarding the goals of this post-session debrief is crucial to ensure the client feels safe and respected. The therapist-interpreter team could seek the client's consent prior to meeting in the client's absence as anti-oppression practice recommends involving clients in all aspects of their care (Larson, 2008). Still, these debriefs can contribute to improving the flow of the therapy by addressing issues related to interpretation such as pacing, or lack of technical knowledge. Other discussions that do not require translation, such as the interpreter's next availability, should be discussed outside of the client's presence. Finally, the therapist can use this time to support the interpreter through emotional reactions to traumatic histories, or opposing values with the client (Tribe & Lane, 2009).

2.3 Challenges and Advantages in Practicing Couple and Family Therapy with Interpreters

Practical Challenges in Couple and Family Therapy with Interpreters

Therapy with interpretation takes longer, particularly when the session involves more than one client. CFTs should consider holding extended sessions, and plan for the possibility of a longer course of treatment, seeking informed consent from the client in this regard (Celano & Kaslow, 2000; Paone & Malott, 2008; Raval, 1996). Due to the cognitive resources required for interpretation, the length of the sessions should be a collaborative decision between the therapist and interpreter according to their experience and risk of fatigue (Tribe & Lane, 2009).

The therapist should also consider if the couple or family should be seen all together or explore whether the work will be more productive if clients are provided appointments individually or in subsystems. While witnessing the dynamics between family members provides important data, balancing out sessions with parents and with children separately, for example, may provide clarity of the positions of the two subsystems, and allow for less cumbersome work for the interpreter.

Challenges in the Therapist-Interpreter-Client Relationship

The relationship between the therapist, interpreter and client requires collaboration between the three dyads, which becomes more complicated when the client is actually a couple or family system (Raval, 1996). Raval (1996) noted the utility of classic structural approaches to understanding these three-way relationships through the concepts of detouring, triangulation, alliances and coalitions. Factors such as varying levels of bilingualism and acculturation could impact the relative neutrality of the relationships with the therapist, potentially resulting in the therapist being perceived as colluding with some family members (e.g., those who speak the therapist's language and share some values) while distancing from others (e.g., those who do not speak the therapist's language may become more aligned with the interpreter) (de Zulueta, 1990). Meanwhile, the interpreter is almost inevitably put in a position where the therapist assumes that they are more aligned with the client given their shared language and possible cultural attributes. To protect against these triangles, the therapist and the interpreter would be advised to develop a strong enough working

relationship to tolerate some degree of separate alliance building with various family members during the joining phase of therapy. In such cases, the alliance building could be understood as enlisting the interpreter as a sort of co-therapist (Leanza & al., 2015). For example, as Dubus (2009) described in her experience in working as a co-facilitator with an interpreter, the interpreter may step out of their interpreting role to signal important cultural context before reverting back to their interpreting role. This signalling can help make the boundaries evident between the roles of the professionals.

It is recommended that mental health professionals view interpreters as integral members of a multidisciplinary therapeutic team (Tribe & Lane, 2009; Tribe & Raval, 2003). Therapists who are not familiar with the interpretation process may be concerned about the quality of the translation, or by strategies employed by interpreters, such as summary feedback, change of wording and follow-up questions not asked by the therapist (Tribe & Raval, 2003). In their efforts to effectively transmit messages while preserving meaning, interpreters may be viewed as adding or omitting significant information. Therapists are at risk of feeling as though they have lost control of the session or are being excluded during interpreted sessions, which can negatively impact the therapeutic and working alliance in the therapist-interpreter-client triad (Leanza & al., 2014). Therapists and clients may also have concerns about the interpreter maintaining confidentiality (Patterson & al., 2018). A strong relationship can free the therapist to clarify such situations with the interpreter, thereby reducing the risk of the therapist fantasizing about the potential inaccuracy of the translation (Tribe & Lane, 2009). An underdeveloped relationship between an interpreter and a CFT may lead to role confusion and a misunderstanding of the therapy process, risking not just ineffective but potentially damaging[2] therapeutic outcomes.

Enriching Therapy Through Working with Interpreters

Working with interpreters encourages therapists to carefully consider the clarity with which they convey or elicit information, the importance of non-verbal communication and a reflection of their assumptions, values and biases (Tribe & Lane, 2009). Interpreters can support therapists to understand how the client's cultural experience may interact with the ecological, migration and acculturation contexts, as well as family life cycle and organizational issues (Tribe & Raval, 2003). Interpretation can be a tool to unpack assumptions and patterns by supporting the client and the therapist to understand the significance of words and phrases that might otherwise pass unnoticed (Leanza & al., 2014).

The presence of an interpreter allows for unique opportunities and additional data to draw upon in therapy. For example, therapists may encourage clients to speak in their second language as an unbalancing technique aimed at shifting alliances during the session (de Zulueta, 1990). Similarly, therapists might intentionally heighten emotions by, for example, reflecting back key words in the client's first language to punctuate the experience (Leanza & al., 2014). Additionally, while some therapists may be frustrated by cross talk between the interpreter and the client, therapists can leverage the rapport built between them by bridging the alliance through the interpreter and asking to be included (Searight & Searight, 2009). This may be a difficult but meaningful move in working with particularly closed family systems.

2. While it is likely a rare case, Paone & Malott (1998) cite one case in which poor interpretation led to a client's suicide.

CONCLUSION

There is little empirical research available in the literature in relation to mental health professionals working with interpreters (Leanza & al., 2015; Tribe & Raval, 2003), and even less that is specific to the field of CFT. Interpreters' comfort level in working with families and engaging children may vary significantly by region (Leanza & al., 2015). Furthermore, guidelines for best practices for including interpreters in therapy have been critiqued for being predominantly adult-focused (Leanza & al., 2015) and derived from a British context (Tribe & Thompson, 2011). While our efforts to identify best practices for conducting couple and family therapy with interpreters yielded sparse results, our approach had several limitations. Our review was narrative and was developed through a post-hoc process rather than following a systematic review protocol. As such, additional articles, chapters and guidelines were likely missed. Our review also did not include an extensive search of the literature pertaining to interpreting studies as they are often excluded from the allied health literature databases despite their necessary role in health and social care systems. The results of our review are indicative of a need for a more extensive review and subsequent knowledge translation for CFTs to effectively collaborate with interpreters. While acknowledging these limitations and recognizing that this review does not represent an analysis of the most up-to-date science (or art) of interpretation in the context of CFT, we do hope that it helps CFTs reflect on their practice and that it demystifies some important aspects of this work.

Couple and family therapists should carefully consider cultural and power dynamics of the family and the availability of qualified interpreters before agreeing to start therapy. Furthermore, therapists should reflect on potential biases and power differentials that may exist between members of the therapist-interpreter-client triad (Corneau & Stergiopoulos, 2012). While intersectionality of oppression and marginalization should not obstruct equal access to therapy—nor should the lack of the therapist's prior knowledge in relation to the client's culture (Gangamma & Shipman, 2017)—the structure of the service should be carefully considered. Interpreters often work part-time and have little opportunity for in-depth training and supervision to facilitate self-reflection. This is not a criticism of interpreters, but rather a reflection of the power imbalance discussed in the introduction of this paper and a call for increased support from health and social systems to care for those engaged in this type of work.

A family presenting with intergenerational, intercultural, and language-related conflicts may require significant support to restructure boundaries and alliances (Raval, 1996). Challenges with families presenting with such concerns in clinical practice include gaps in therapist skills in working with interpreters, time allotted to assess and treat the family, and in some jurisdictions access to highly trained interpreters. There is also a need to create a balance between the inclusion of interpreters as more than just translating machines and ensuring that the client remains the central focus of the intervention (Darling, 2004). Interpreters, particularly if acting as a culture broker, can support therapists understand family issues around gender, hierarchy or sensitive topics that may be of particular cultural relevance (Leanza & al., 2014).

The therapist-interpreter team needs to be systemically supported to obtain the skills and working relationship required to help restructure family systems, otherwise risking the reinforcement of problematic hierarchies or dysfunctional family transactions. In some cases where interpretation is required, individual or subsystem therapy (e.g., based on language mastery or generation) may be more appropriate than family therapy.

RÉSUMÉ :

Éthiquement, les thérapeutes conjugaux et familiaux ne devraient pas refuser de fournir des services en raison de barrières linguistiques qui requièrent le recours à des services d'interprètes culturels et linguistiques. Comme les thérapeutes conjugaux et familiaux sont formés aux approches systémiques et appelés à travailler avec plusieurs personnes à la fois, dans un cadre thérapeutique, on peut présumer qu'ils sont naturellement aptes à travailler avec des interprètes. Toutefois, les méthodes, les rôles et les recherches entourant l'interprétation culturelle et linguistique dans le domaine de la thérapie conjugale et familiale (TCF) ont été très peu documentés. Dans cet article, nous présentons un résumé du peu de littérature disponible sur l'interprétation linguistique et culturelle dans le contexte de la TCF et nous puisons dans le domaine plus large de la santé mentale pour explorer des questions telles que les alliances interprète-thérapeute-client, la formation des thérapeutes et des interprètes ainsi que certains aspects concrets à considérer dans le cadre d'une approche de pratique systémique et anti-oppressive.

MOTS-CLÉS :

Thérapie conjugale et familiale, interprétation, traduction, médiation culturelle

REFERENCES

Ali, R. K. (2004). Bilingualism and systemic psychotherapy: Some formulations and explorations. *Journal of Family Therapy*, *26*(4), 340-57. https://doi.org/10.1111/j.1467-6427.2004.00288.x

Becher, E. H. & Wieling, E. (2015). The intersections of culture and power in clinician and interpreter relationships: A qualitative study. *Cultural Diversity and Ethnic Minority Psychology*, *21*(3), 450-57. https://doi.org/10.1037/a0037535

Bruin, E. de (2006). The Psychotherapist and the Sign Language Interpreter. *Journal of Deaf Studies and Deaf Education*, *11*(3), 360-68. https://doi.org/10.1093/deafed/enj034

Campbell, W., Tamasese, K. & Waldegrave, C. (2012). Just Therapy. In A. Lock & T. Strong (dir.), *Discursive Perspectives in Therapeutic Practice* (p. 197-201), Oxford University Press.

Celano, M. P. & Kaslow, N. J. (2000). Culturally Competent Family Interventions: Review and Case Illustrations. *The American Journal of Family Therapy*, *28*(3), 217-28. https://psycnet.apa.org/doi/10.1080/01926180050081658

Corneau, S. & Stergiopoulos, V. (2012). More than being against it: Anti-racism and anti-oppression in mental health services. *Transcultural Psychiatry*, *49*(2), 261-82. https://doi.org/10.1177/1363461512441594

D'Ardenne, P., Farmer, E., Ruaro, L. & Priebe, S. (2007). Not lost in translation: Protocols for interpreting trauma-focused CBT. *Behavioural and Cognitive Psychotherapy*, *35*(3), 303-16. https://psycnet.apa.org/doi/10.1017/S1352465807003591

Darling, L. (2004). Psychoanalytically-informed work with interpreters. *Psychoanalytic Psychotherapy*, *18*(3), 255-67. https://psycnet.apa.org/doi/10.1080/14749730412331280939

Dubus, N. (2009). Creating a bridge to healing: A professional/paraprofessional team approach. *Journal of Social Work Practice*, *23*(3), 327-36. https://doi.org/10.1080/02650530903102684

Dubus, N. (2015). Using an Interpreter as Cofacilitator. *Social Work with Groups*, *38*(1), 44-55. https://psycnet.apa.org/doi/10.1080/01609513.2014.931670

Elkington, E. J. & Talbot, K. M. (2016). The role of interpreters in mental health care. *South African Journal of Psychology*, *46*(3), 364-375. https://doi.org/10.1177/0081246315619833

Fennig, M. & Denov, M. (2020). Interpreters Working in Mental Health Settings With Refugees: An Interdisciplinary Scoping Review. *American Journal of Orthopsychiatry*. https://doi.org/10.1037/ort0000518

Gangamma, R. & Shipman, D. (2017). Transnational Intersectionality in Family Therapy With Resettled Refugees. *Journal of Marital and Family Therapy*, *44*, 206-219. https://doi.org/10.1111/jmft.12267

Guzder, J. (2014). Family systems in cultural consultation. In L. J. Kirmayer, J. Guzder & C. Rousseau (dir.), *Cultural consultation: encountering the other in mental health care* (p. 245-268). Springer (International and cultural psychology).

Hardy, K. V. & Laszloffy, T. A. (1995). The Cultural Genogram: Key to Training Culturally Competent Family Therapists. *Journal of Marital and Family Therapy*, *21*(3), 227-37. https://psycnet.apa.org/doi/10.1111/j.1752-0606.1995.tb00158.x

Kirmayer, L. J., Groleau, D., Guzder, J., Blake, C. & Jarvis, E. (2003). Cultural consultation: A model of mental health service for multicultural societies. *The Canadian Journal of Psychiatry*, *48*(3), 145-53. https://doi.org/10.1177/070674370304800302

Larson, G. (2008). Anti-oppressive Practice in Mental Health. *Journal of Progressive Human Services*, *19*(1), 39-54.

Leanza, Y., Boivin, I., Moro, M.-R., Rousseau, C., Brisset, C., Rosenberg, E. & Hassan, G. (2015). Integration of interpreters in mental health interventions with children and adolescents: The need for a framework. *Transcultural Psychiatry*, *52*(3), 353-75. https://doi.org/10.1177/1363461514558137

Leanza, Y., Brisset, C., Rocque, R. & Boilard, A. (2017). Challenges to and recommendations for working with a community interpreter in mental health: A Canadian perspective. In E. A. Jacobs & L. C. Diamond (dir.), *Providing Health Care in the Context of Language Barriers: International Perspectives* (p. 56-70), Multilingual Matters.

Leanza, Y., Miklavcic, A., Boivin, I. & Rosenberg, E. (2014). Working with interpreters. In L. J., Kirmayer, J. Guzder & C. Rousseau (dir.), *Cultural consultation: encountering the other in mental health care* (p. 245-68). Springer (International and cultural psychology).

Miklavcic, A. & LeBlanc, M. N. (2014). Culture Brokers, Clinically Applied Ethnography, and Cultural Mediation. In L. J. Kirmayer, J. Guzder & C. Rousseau (dir.), *Cultural consultation: encountering the other in mental health care*, *Cultural Consultation* (p. 115-37). Springer (International and Cultural Psychology).

Miletic, T., Piu, M., Minas, H., Stankovska, M., Stolk, Y. & Klimidis, S. (2006). *Guidelines for Working Effectively With Interpreters in Mental Health Settings*, Victorian Transcultural Psychiatry Unit.

Paone, T. R. & Malott K. M. (2008). .Using interpreters in mental health counseling: A literature review and recommendations *Journal of Multicultural Counseling and Development*, *36*(3), 130-142. https://psycnet.apa.org/doi/10.1002/j.2161-1912.2008.tb00077.x

Patterson, J. E., Abu-Hassan, H. H., Vakili, S. & King, A. (2018). Family Focused Care for Refugees and Displaced Populations: Global Opportunities for Family Therapists. *Journal of Marital and Family Therapy*, *44*(2), 193-205. https://doi.org/10.1111/jmft.12295

Raval, H. (1996). A Systemic Perspective on Working with Interpreters. *Clinical Child Psychology and Psychiatry*, *1*(1), 29-43. https://doi.org/10.1177/1359104596011004

Searight, H. R. & Searight, B. K. (2009). Working With Foreign Language Interpreters: Recommendations for Psychological Practice. *Professional Psychology: Research and Practice*, *40*(5), 444-451. https://psycnet.apa.org/doi/10.1037/a0016788

Searight, R. H. & Armock, J. A. (2013). Foreign language interpreters in mental health: A literature review and research agenda. *North American Journal of Psychology*, *15*(1),17-38.

Tribe, R. & Lane, P. (2009). Working with interpreters across language and culture in mental health. *Journal of Mental Health*, *18*(3), 233-241.

Tribe, R. & Raval H. (2003). *Working with Interpreters in Mental Health*, Psychology Press.

Tribe, R. & Thompson, K. (2011). Developing guidelines on working with interpreters in mental health: opening up an international dialogue? *International Journal of Culture and Mental Health*, *4*(2), 81-90. https://doi.org/10.1080/17542863.2010.503365

Ungar, M. (2010). Families as navigators and negotiators: Facilitating culturally and contextually specific expressions of resilience. *Family Process*, *49*(3), 421-435. https://doi.org/10.1111/j.1545-5300.2010.01331.x

Waldegrave, C. (2009). Cultural, gender, and socioeconomic contexts in therapeutic and social policy work. *Family Process*, *48*(1), 85-101. https://doi.org/10.1111/j.1545-5300.2009.01269.x

Zulueta, F. de (1990). Bilingualism and family therapy. *Journal of Family Therapy*, *12*(3), 255-265. https://psycnet.apa.org/doi/10.1046/j..1990.00392.x