

Integration of interpreters in mental health interventions with children and adolescents: The need for a framework

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Abstract

Few empirical studies have detailed the specificities of working with interpreters in mental healthcare for children. The integration of interpreters in clinical teams in child mental healthcare was explored in two clinics, in Montreal and Paris. Four focus groups were conducted with interpreters and clinicians. Participants described the development of the working alliance between interpreters and clinicians, the delineation of interpreters' roles, and the effects of translation on the people in the interaction. Integrating interpreters in a clinical team is a slow process in which clinicians and interpreters need to reflect upon a common framework. An effective framework favours trust, mutual understanding, and valorization of the contribution of each to the therapeutic task. The interpreter's presence and activities seem to have some therapeutic value.

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In a globalizing and creolizing world, the language gap has been shown to be one of the main issues in delivering appropriate healthcare to minority populations. Language barriers are considered by some authors to be among the main factors explaining health disparities (Fiscella, Franks, Doescher, & Saver, 2002). In Canada, for example, poor French or English proficiency has been found to be significantly associated with poor self-reported health (Pottie, Ng, Spitzer, Mohammed, & Glazier, 2008). This has important implications in the organization of healthcare services, practitioners' training, and the transmission of information to patients.

In mental health care, language is a cornerstone because it is the vehicle through which patients reveal their inner world and the means through which therapeutic work is done. Hence, collaboration with interpreters is essential to ensure access to services and quality of care for patients who do not speak the language of their host community. The work of interpreters is not only to convey the denotation (explicit meaning) of discourse, but also the connotation (implicit meaning and associated affects; Westermeyer, 1993). Without interpreters, psychological assessment and treatment may be compromised. A recent literature review about interpreting in mental health found that working with professional interpreters facilitates a fuller disclosure of psychological symptoms and of sensitive topics such as traumatic events compared to working with informal interpreters (e.g., bilingual hospital staff, friends, or family members) or without any interpreter at all (Bauer & Alegria, 2010). Research on interpreting in health care generally uses a deficiency-focused approach, discussing difficulties and communication mishaps (Brisset, Leanza, & Laforest, 2013; Tribe & Thompson, 2009). Very few authors take a more positive approach and attempt to uncover the elements needed to build a working alliance between interpreters and clinicians.

An important theme in interpreting studies concerns the interpreter's roles. Many typologies have emerged in interpreting research, and roles can be organized along a continuum between alliance with and serving the needs of the *system* (healthcare institutions) and the *lifeworld* (patient's life context and narrative about health and illness; Brisset et al., 2013). Interpreters' stance oscillates along this continuum, like a pendulum. In mental health, authors mention the role of *cultural informant* (Darling, 2004), for example, interpreting the customs and rules governing families' behaviour (Loshak, 2002), or identifying the main differences between the country of origin and the host country on values, family roles, and education (Rousseau, Measham, & Moro, 2011). Some authors go further to suggest that interpreters might be cotherapists, fully participating in the therapeutic process (Hémon, 2001; Mudarikiri, 2002; Westermeyer, 1989). Although clinicians sometimes rely on interpreters to get relevant cultural information, they may also perceive interpreters' initiatives as intrusions (Raval & Smith, 2003).

Although the presence of an interpreter is ethically and clinically necessary (Leanza, Miklavcic, Boivin, & Rosenberg, 2014), few empirical studies have highlighted the characteristics of high-quality psychiatric care in the presence of language barriers (Bauer & Alegria, 2010). Most publications are essentially based on authors' experiences (as practicing psychotherapists), highlighting the need for empirical studies.

Still fewer studies have detailed the specificities of working with interpreters in child mental health and provided clinical guidelines. The relative absence of guidelines might imply that collaboration with interpreters in child psychiatry does not differ from work with adults. However, Rousseau et al. (2011) identify several considerations when working with interpreters in child mental health care. The assessment of child development is more complex in intercultural situations. For instance, difficulty in communication may be related to a developmental disorder, to socioemotional concerns, or a combination of both. Here it might be helpful for interpreters and parents to share their opinions about the nature and etiology of children's difficulties. Also, interpreters cognisant of how child development is conceived in western culture may discuss with clinicians the differences with other cultural representations. This allows consideration of cultural norms in child development when collecting the developmental history (Rousseau, Measham, & Bathiche-Suidan, 2008).

At this point, it seems essential to develop empirical knowledge on the issues of working with interpreters by child mental health teams. Such data can inform recommendations for improving the organization of transcultural mental health services and the quality of care.

Objective and research question

The objective of the present study was to explore the integration of interpreters in child and adolescent mental health interventions in two clinics with expertise in the field of transcultural mental health. Specifically, we aimed to identify on how interpreter–clinician collaboration issues are managed in these settings. Integrating interpreters in a clinical team as collaborators and full participants in the therapeutic process is still marginal and needs to be documented. Thus, the research aimed to depict the key elements that favor collaboration between interpreters and clinicians in such interventions. Following the literature, we expected that key elements to integration could be found at three levels: (a) interpersonal dynamics, (b) institutional routines and policies, and (c) larger social trends in healthcare, majority–minority relationships, and language politics.

Method

Given the exploratory nature of the study, we chose a qualitative approach using thematic analysis of individual and focus group interviews. Two clinics directed by two of the coauthors (MRM & CR) were chosen for the study: one located in Paris (France) and the other in Montreal (Canada).

Description of clinics

The Paris clinic has existed for over 20 years. It provides second-line transcultural consultations to migrant families from across France. The team follows the principles of the French ethnopsychiatry school as developed principally by G. Devereux (1972), T. Nathan (1986), and M. R. Moro (Moro, 1998; Moro, De La Noë, & Mouchenik, 2004). The clinic uses a psychoanalytical approach, but also draws on anthropological and sociological theories about health, illness, and healthcare (Sturm, Nadig, & Moro, 2011). In consultations, there is one primary therapist and several cotherapists of various cultural backgrounds and occupations (psychiatrist, psychologist, nurse, etc.). The clinic also provides individual services to parents and children. All clinicians have training in cross-cultural mental health work.

The Montreal clinic was established in 2010. The recent Quebec mental health action plan involved a transfer of resources to the Health and Social Services Centers (HSSC), which allowed the clinic to increase the size of its staff. Clinicians are child psychiatrists, psychologists, social workers, art therapists, and psychoeducators. Based on a “shared care” model, the clinic provides first-line services to families from the surrounding area. In this model, child psychiatrists play a consultative role; they evaluate and offer advice to other mental health clinicians who provide therapies. The clinic adopts a transcultural, family and systemic approach. Two clinicians are generally involved: one provides individual psychotherapy to the child and another provides family therapy.

Both clinics work with trained interpreters from the Inter-Regional Interpreters Bank (Montreal) and the Inter-Service Migrants Association (Paris), respectively. Each of the clinics also has a “key interpreter” who serves a coordinating role.

Procedure

In each clinic, interpreters and clinicians were informed of the study by their coordinators. Those who wished to participate were then invited to take part in a focus group during the spring of 2012. Each of these focus groups was audio-recorded, then transcribed verbatim, and lasted for 90 to 150 minutes. All clinicians and one interpreter (a full-time employee of the institution) participated during their hours of paid work. All other interpreters who work “on call” were offered fees equivalent to their hourly wage. All participants were also asked to complete a short sociodemographic questionnaire.

Ethics approval was obtained in Montreal from the institutional Research Ethics Board (REB). According to the French rules, separate approval was not required for this study at the Parisian clinic as it used nonintrusive methods and did not involve patients. Nevertheless, participants in both clinics were given the consent form to read and sign upon approval.

Focus groups with clinicians and interpreters

Two focus groups were conducted in each location, one with interpreters and the other with clinicians. Each group consisted of five to 10 people, which is regarded as the optimum size in order to give everyone the opportunity to express him/herself while allowing sufficient diversity of opinions (Krueger & Casey, 2009). A plurality of views was sought, rather than consensus. Separating clinicians and interpreters helped to distinguish their perceptions, and to mitigate power issues that could affect participants' confidence. Clinic's directors were excluded from the focus groups.

The interview guide included questions about the characteristics of a good interpreter in child and adolescent mental health, the characteristics of a good clinician (when working with an interpreter), the characteristics of a successful interpreted intervention and those of a problematic interpreted intervention, benefits of working with an interpreter, people's experiences in interpreted interaction, and institutional issues around interpreting.

Interviews with managers

Interviews with a manager from each clinic were also conducted in order to gather relevant information about the clinic philosophy and policies. They were conducted in the managers' offices and lasted for about 30 minutes. They aimed at eliciting the model of care and theoretical approaches, the clinicians' occupations, the nature of services offered, the source of referrals, the types of interpreters and their training. Managers were asked to describe the network of institutions with which the clinic collaborates and the mental health policies influencing their clinical teams' work.

Data analysis

A thematic analysis (Paillé & Mucchielli, 2008) was performed, which consisted of systematically identifying and grouping themes in an information reduction process. First, transcripts were read carefully. The text was then divided into units of meaning, that is, sentences or sets of sentences related to an idea, to which we assigned codes. These codes were grouped and hierarchically organized in a coding tree. Coding was inductive but guided by previous theoretical and empirical work on mental health interpreting (Leanza et al., 2014).

Results

Participants

In all, five interpreters from Montreal and six from Paris took part in the study; three of the interpreters in Montreal and five in Paris had received basic training in

community interpreting. Interpreters in Montreal were less experienced than those in Paris. The languages for which they interpreted were the most common foreign languages in each location. As well, eight clinicians participated from the Paris clinic and 10 from the Montreal clinic. Clinicians from Paris represented various nationalities and languages. In contrast, all clinicians in Montreal were Canadian citizens who spoke both French and English (and three spoke Spanish). Few clinicians had received training on working with interpreters: only one in Montreal and two in Paris. Clinicians had comparable numbers of years of practice in Montreal and Paris, but with a narrower range in Montreal (see Table 1 for details).

Integrating interpreters

Three main themes emerged from the focus groups: (a) the development and the maintenance of a working alliance; (b) the delineation of interpreters' roles and (c) the effects of translation on people in the interaction. Each will be discussed in terms of similarities and differences between the groups (Paris vs. Montreal; interpreters vs. clinicians).

Developing and maintaining a working alliance. For participants at both locations, there was a need to reach an agreement between interpreters and clinicians on how to work together. This working alliance was built through time and continuity. It was characterized by trust, mutual recognition, and respect for each other's work. A good working alliance facilitated families' confidence in clinicians. For the interpreters in Paris, it also enabled clinicians and interpreters to solve problems together:

Int1P¹: If the interpreter and the therapist work together and they are very confident that everyone respects each other's work, then usually it goes very well with the family. We solve problems easily because we have a good alliance with both the therapist and the family. Instead, if we feel that the family or the practitioner is completely closed, we cannot work. It generally does not lead to anything. This is not a language problem in the end it is something else.²

The development of a common way of working was a pleasurable experience:

C5P: We arrive at these extraordinary knitted works! They are extremely creative!... We work together and this work produces blissful creativity and caring for patients!

C6M: Complicity develops because we do it together! I cannot do it without the interpreter. There is complicity in the sense that it can be fun to do it together and adjust to each other.

Table 1. Characteristics of interpreters ($N = 11$) and clinicians ($N = 18$) participating in the study.

| Site (n) | Gender (n) | Median age | Mean years of practice (SD) | Nationality (n) | Interpreted or spoken languages (n) |
|---------------------|----------------|------------|-----------------------------|---|--|
| Interpreters | | | | | |
| Montreal (5) | F (5) | 40 | 10.6 (7.2) | Canadian (1) Chinese (1) Indian (1) Pakistani (1) Turkish (1) | Hindi (2) Punjabi (2) Urdu (2) Chinese (1) English (1) Kurdish (1) Spanish (1) Turkish (1) |
| Paris (6) | F (3) M (3) | 44 | 13.7 (7.9) | French (3) Algerian (1) Congolese (1) Senegalese (1) | Soninké (3) Bambara (2) Arabic (1) Diakhanké (1) Dioula (1) English (1) Kabylian (1) Khassonké (1) Lingala (1) Malinké (1) Peulh (1) Pulaar (1) Tamil (1) Wolof (1) |
| Clinicians | | | | | |
| Montreal (10) | F (10) | 46 | 12.4 (3.9) | Canadian (10) | English (10) French (10) Spanish (3) |
| Paris (8) | F (5) M (3) | 48 | 13.8 (8.7) | French (5) Algerian (1) Hellenic (1) Italian (1) | French (8) English (3) Arabic (2) Berber (1) Greek (1) Italian (1) Kabylian (1) Spanish (1) Tamil (1) |

To establish collaboration, the clinicians (Montreal and Paris) and the principal interpreter (Paris) informed new interpreters about the phases of clinic consultations, the interpreters and clinicians' respective roles, the boundaries of relationships with clients, confidentiality, and the consultation's objectives. For their part, interpreters (Montreal and Paris) informed clinicians of their needs to perform their interpreting work and asked clinicians about the roles they should play in a consultation. They also clarified their roles with families, for instance, by saying that they would translate every word (Montreal).

All participants believed that the framework for working together should be flexible and should take into account the particular challenges and complexities of the interpreter's work:

Int4P: A good mental health practitioner integrates the work of the interpreter in the process of therapy. He understands the interpreter's role and the specificities of her work... If he does not include the interpreter, the interpreter is rejected and does not feel comfortable with the practitioner.

According to both groups of interpreters, all clinicians took into account interpreters' needs by formulating clear and concise sentences. They also allowed interpreters time to create a bond with families or children and time to understand before translating. They also listened to translations without interrupting.

The Paris clinic had developed an explicit framework for working with interpreters. It was coconstructed by clinicians and interpreters, some of whom had been working at the clinic for as long as 20 years. Interpreters were chosen according to their interests, training, history, and sensitivity by an interpreter-coordinator who then facilitated their integration.

The Montreal clinic had been created more recently from various existing clinical teams. The team had not yet developed a collective framework for work with an interpreter. Rather, each clinician defined her framework and explained it to the interpreter. Clinicians expressed a need for a better defined common framework. One of the interpreters filled a coordinating role, but she had never received basic interpreting training.

In Paris, modalities of support/supervision for interpreters facilitated their integration into the clinic. They also participated in teaching sessions for the newer clinicians. These types of support were absent in Montreal. Montreal interpreters sometimes sought support from clinicians, especially to deal with emotional material, but more frequently turned to their fellow interpreters and spouses. The clinicians perceived the interpreters as ill-equipped to distance themselves from the emotional content of the consultations and to tolerate powerlessness. Referring to the lack of support, one interpreter used the metaphor "being thrown into the fire" (Int1M).

"Nonintegration" of interpreters could generate distrust on all parts. Interpreters in both locations were critical of the level of competence of some

clinicians; they deplored their rigidity in requiring, for instance, translation of everything. They also shared that some clinicians imposed poorly suited solutions for families, listened poorly, were less humane, or did not seek to understand the families' cultures:

Int3M: I think the interpreter is more humane compared to the clinician. Yes, in some contexts. From my experience, I see that I am more sensitive.

Int2M: Them, they go "by the book."

Int3M: ...and more open and more social...especially when it came to children with mental and physical disabilities. That's it. I think the interpreter is more sensitive.

Mistrust was exacerbated when interpreters did not understand "the clinicians' world." Echoing interpreters' worries, clinicians (Paris and Montreal) considered it important to make their world accessible to interpreters. At the same time, when thinking about a particular situation or a particular interpreter, these same clinicians might also be suspicious: they feared losing control or losing their therapeutic power.

The lack of a common framework led to transgressions of limits by clinicians or interpreters. Clinicians, particularly those in Montreal, described situations where interpreters exceeded the limits of their role. This included becoming friends with the patient's family, or acting as clinicians themselves without the knowledge of the clinician and family. For instance, they might try to quickly resolve a problem that the clinician would instead explore in depth. Suspicious interpreters might also strive to protect families from clinicians:

C9M: I have had experiences where [interpreters] were defending the client... They were translating what was said, but with their whole body language, it was like they were there to "protect" the client. They perceived [my] questions as an attack [to the patient and his/her family]!

Interpreters reported that some families asked them to perform roles outside the framework. Among other things, families might seek to create a personal connection, or they confide in the interpreter, and then ask the interpreter not to translate. Teenagers might try to make interpreters take a stand in their favour with their parents, something interpreters considered to be beyond their role:

Int1P: I did not want to take a stand either for the girl or the mother, because I understood both. Adolescents test us and it is not easy. Fortunately, I was not alone. The psychiatrist clearly understood something was going on.... It is true that the position of interpreting is not easy. It is more difficult with teenagers.

To maintain the working alliance, clinicians had to be confident that interpreters had good language skills and that they would translate fairly and completely. Mutual trust and dependence was discussed:

C4M: Trust must be reciprocal. We must trust that the interpreter tells us what we need to know and the interpreter must be confident that the clinician will ask the appropriate questions.

Clinicians also had to accept a decrease in control, which could sometimes bring advantages in the therapeutic process:

C4M: Sometimes interpreters will develop close links with the family. That, I don't want deny at all. I think working with an interpreter is interesting. It means we have less control than what we are used to in clinical settings... and it takes getting used to... sharing, to feel it. And to be comfortable enough with this decrease in control... Yes sometimes interpreters get too close [to patients], but sometimes they open doors... Things we would not have thought about, and it might be entirely appropriate for the family.

Delineation of interpreters' roles

Participants described not only *how* the framework was built but also its content, that is, the different roles that interpreters could take. Five roles emerged from focus groups: translator, interpreter, mediator, cultural informant, and cotherapist.

Translator. Interpreters usually translated only for parents as children are bilingual (Montreal and Paris). Clinicians sometimes reminded children that they could speak their mother tongue despite their bilingualism (Montreal). All focus groups emphasized the importance of an objective, "word-for-word" translation as it ensured that patients were given a voice and left the task of clinical interpretation to clinicians (Paris and Montreal). In the same vein, clinicians and interpreters said that interpreters should strive to be neutral and impartial, hiding their emotions or opinions, although it this was seen as difficult or even impossible:

Int1M: We must be impartial and not show our emotions, our opinions.

Interviewer: You all agree with that?

Int3M: Yes. This is the first thing to consider, to be neutral and not to act with feelings.

Int1M: Not to make faces.

Int6P: We try our best to be neutral, but [it is not easy]. When people see me, they know I'm young, that I surely did not grow up in [participant's country of origin], that I'm from here . . . Beyond what I want to do . . . there are things that are perceived. But in translation, we try to be neutral, to be closest to "word-for-word."

Interpreter. Even though all focus group participants valued word-for-word translation, all agreed on its impossibility. Interpreters' subjectivity was necessary to understand and convey meaning. Interpreting required understanding psychological concepts as well as the cultural and geopolitical context of families. Meaning was prioritized over literal translation:

C4M: I think that interpretation accuracy does not lie within word for word, because it can take a long time to explain something to the family and we have an answer of a few words. We should not always worry about it in the sense that often, something of the context had to be explained.

A clinician who also acted as an interpreter (Paris) described that any interpretation is a "betrayal" as discourse is necessarily transformed by interpreters' subjectivity:

C2P: I think that an interpreter is someone who betrays. If he does not betray, if I do not see his personal imprint on what he heard and what he conveys to us, I do not hear. He is not a translator, someone who takes a word, the same word, and tells us. He articulates what he hears according to him, his story . . . At the same time, he is not too far either . . . he stays close to what the person says.

Cultural informant. This role consisted of sharing knowledge about the cultures of clinician and family in order to improve reciprocal understanding:

C5M: We can integrate the interpreter's cultural opinion into our understanding of a situation. I like that the interpreter translates and, as needed, he or she tells us that the person reacts like that because in her culture she understands things in such a way.

In contrast to the Montreal team, Paris clinicians considered that interpreters should seldom play the role of cultural informant since it was the clinicians' responsibility to have this "cultural" knowledge. Still, all considered it important for clinicians to understand the family's culture be it through an interpreter, reading, training, etc.

Mediator. According to participants, mediation consisted of being a "go-between": between two worlds, languages, cultures, or conflicting stances. Both clinicians and

interpreters from Montreal talked little about the mediator role; it was mainly discussed by Paris focus groups, where this role had been recently formalized, and specific training provided to interpreters. In this training, they learned how to help resolve value conflicts. The mediator role was complex and overlapped cultural informant and interpreter roles.

As mediators, interpreters sought to understand and explain each person's position: they explained families' universes to clinicians, and clinicians' universes to families. It is worth noting that only Paris interpreters reported explaining clinicians' universe to families, in keeping with their integration into the team. Explaining clinicians' universe occurred when parents did not understand clinicians' intentions and methods or when they had expectations that were incompatible with the services, such as expecting a quick solution or medication. Interpreters could also explain to parents the reasons for the medical referral, the process of the consultation visit, the purposes of clinicians' questions, and what they could expect from the services. To clinicians, interpreters explained families' reactions to their interventions.

In the mediator role, interpreters spoke in their own voices (as in the interpreter role). They made efforts to gain the interlocutors' trust:

Int5P: I tell [the patient] "I come from where you come from. I'm here for you. I'm not against you. I am aware that the institution called me to convey a message." I explain this so the person does not distrust me. Then, I tell the institution what I told the patient. That way, the institution knows that even if I speak a moment with the patient, it is not against it [the institution]. It is to gain his trust, in order to get the information the institution needs.

In some cases, mediating involved restoring power to the person who had lost it. Interpreters could thus restore clinicians' power by convincing a patient to follow their recommendations. They could support parental authority over children (Montreal and Paris clinicians). Finally, they could act as a patient's advocate by asking clinicians to adapt their interventions (Montreal interpreters).

Cotherapist. Clinicians in Paris and Montreal considered interpreters as both cotherapists but with limits. They were considered cotherapists insofar as they created an alliance with families or children. According to Montreal clinicians this alliance needed to be appropriate to the context of mental health (i.e., not being "too familiar"). While Montreal interpreters reported interacting with children (and thus creating alliances), Paris interpreters indicated little interaction with children. Interpreters in both clinics also contributed to the therapeutic alliance by translating well and by introducing themselves, their profession, and the rules of confidentiality. For fear of generating mistrust, interpreters in Paris were careful not to provide certain personal information, such as their origin or social class. Paris interpreters reported that it was more difficult to create a bond of trust with adolescents, as they sometimes wanted to hide things from their parents.

According to all focus groups, interpreters occasionally shared their views, much as a cotherapist would:

Int6P: [Name of the interpreter] is often more a cotherapist than an interpreter. At times, some African families understand French well, or at least we understand them. So he does not translate. However, he is asked about what he thinks. For example, "What do you think about this word that the patient said?" So, for me, he is almost cotherapist.

Interpreters could express their opinions spontaneously, during or after consultations. Paris clinicians reported that they would temporarily release interpreters from their translator role in order to solicit their views. Interpreters might also be asked to assess the level of a child's bilingualism.

Again, according to Montreal and Paris clinicians, interpreters were cotherapists in the sense that they gradually developed mental health knowledge through experience and training when available. However, interpreters still felt they lacked relevant knowledge. Montreal clinicians also sometimes asked interpreters to put themselves at the level of children and play with them, as part of the therapeutic process. In Paris, this was done by one of the clinicians. For Paris clinicians, it was an ethical necessity for interpreters to have some knowledge about mental health interventions, such as knowledge about the clinical setting, confidentiality, transference and countertransference reactions. In this clinic, some interpreters were also clinicians and this allowed clinicians to speak and work in a more nuanced fashion:

C6P: Having an interpreter who is also a cotherapist, it is a comfort! We can then be more subtle in our work. But when we have an interpreter with whom we are not familiar, we try to be much more simple and clear.

Finally, some experienced interpreters, who were also trained as therapists, would adopt a "free floating" attention during the interaction, making it possible for them to simultaneously make a linguistic (language interpretation) and a clinical interpretation of the discourse (content interpretation; Paris clinicians). In other words, with time, they developed the ability to think clinically while simultaneously translating therapy session discourse. They agreed that this was a difficult position to be in, as what was said and what was thought could easily become confused.

However, some clinicians in both locations believed that interpreters should not function as cotherapists because the transition from the translator role to the one of cotherapist might undermine the therapeutic process:

C6P: It's very complicated [to be a cotherapist]; I remember one such experience, it was special. I was acting as interpreter and at some point, I think, I was caught up in what was said, images and metaphors that were expressed; sometimes it actually destabilizes the person's position as cotherapist or interpreter.

Effects of translation on participants in the interaction

The participants described the effects of translation on clinicians, parents, and children. The translation provided clinicians in both locations time to step back, observe, and think. The interpreter's presence could also alleviate feelings of strangeness:

C5M: The family has a different culture and there may be a feeling of strangeness. Sometimes you feel less isolated when the interpreter is there . . . Even if the family speaks English or French, there is a certain cultural distance; a bridge is built thanks to the interpreter.

Translation also empowered parents (clinicians in both locations):

C4M: In some situations, we hope that parental authority is respected and the interpreter will help [in this regard].

C8P: Sometimes the parents' power is lost because they do not speak our language. By translating, the interpreter authorizes the parents' power. In front of the children, the parents will regain the power to speak and say whatever they want with the lexical freedom of their mother tongue. It is the interpreter's role to allow the power of the parents to manifest in the eyes of their children.

Finally, Paris clinicians described positive effects of translation on children. They might be relieved that someone else fulfilled the interpreter function. Also, they might be amazed by the interpreters ability to shift between two languages and they could identify with the interpreter as someone "who manages to move" (C1P) between two worlds. Interpretation then allowed children to integrate two separate worlds:

C2P: [In the presence of an interpreter] the child or adolescent experiences a situation that is not usually possible because the worlds are cleaved. There are two completely different registers: it is different to think of something at home and to think of it at school. [At the consultation], something becomes possible! . . .

C8P: The interpreter represents an example of a successful blend in the eyes of a child.

C2P: He carries a possible articulation! . . .

C8P: The child sees that the dual membership is not only negative! But one can also make . . .

C2P . . . something structured, structuring.

C8P: . . . something that is useful, that is good and that is also useful for others!

Discussion

This study aimed to explore key elements that favor collaboration between interpreters and clinicians in child and adolescent mental health interventions. Below we present the general issues—which may apply in working with interpreters in any healthcare setting—followed by a discussion of the specifics of children and adolescent mental health interpreted intervention.

Elements of a favorable framework

Our findings suggest that effective collaboration between interpreters and clinicians in child and adolescent mental health interventions requires trust, respect, recognition and time, along with a process of collective reflection on interpreter's roles and training and active support for both interpreters and clinicians.

According to all participants, a good working alliance is characterized by trust, a theme which runs across studies on interpreting and which is usually associated with issues of control and power (Brisset et al., 2013). Neither power nor control was explicitly mentioned as crucial in the present study, which is unusual in healthcare interpreting research, but difficulties associated with these issues did arise in focus group discussions. Control, defined as “the ability to orient the course of action during consultations and verify the accuracy and validity of dialogs” (Brisset et al., 2013, p. 136), appeared as an issue when interpreters felt the need to protect family members from the intervention or when they were seen as transgressing limits by clinicians. Power is conceptualized as the impact of larger social or institutional forces in the consultation room (Brisset et al., 2013). In the case of interpreted consultations, power may relate to minority–majority conflicts (e.g., in South Africa; see Drennan & Swartz, 1999; Smith, Swartz, Kilian, & Chiliza, 2013) or to institutional concerns about the (supposed) cost of interpreting services (Jacobs, Shepard, Suaya, & Stone, 2004). The effects of such power struggles are manifested in relational dynamics and the interpreter's activity.

Despite their evident importance, these issues, especially power, were not very present in participants' discourse. This relative absence of themes of control and power suggests that the interactional dynamics in these two transcultural clinics differ from those of the majority of clinics or practices described in the literature. It may be that the members of the Montreal and Paris clinics' have moved beyond “competition of controls,” as observed for example by Hsieh (2010).

The second emerging theme, less frequently mentioned in the literature, is recognition of each other's work. Labun (1999) showed that “shared brokering,” a harmonious working alliance, is achieved between interpreters and nurses through this recognition of the complexity of each other's work. For our participants, this mutual recognition seemed to bring collaboration and creativity into the healthcare process, two other key elements of successful work.

An important element that appeared to influence the establishment of a good working alliance was the age of the clinics. The Paris clinic has been in existence

more than 20 years, while the Montreal one was only a few years old at the time of the study. Clinicians in both locations had the same amount of experience, but those in Montreal had not worked together for as long and did not share a common framework for working with interpreters. Consistent with the literature (Goguikian Ratcliff & Suardi, 2006; Labun, 1999), time is an essential ingredient in the building of a working alliance.

Interpreters' roles are not exactly the same in the two clinics, which can be explained by both the clinics' age and their theoretical orientations (psychodynamic in Paris, systemic and family in Montreal). Time and orientation influence how interpreters are seen by clinicians and what roles they are asked to play (Leanza et al., 2014). However, a common trend in both settings was to describe interpreters' roles in terms of complexities and nuances, underlining the profound ambiguity of the interpreters' stance. This ambiguity is seen as an integral part of interpreters' activity and not a defect to erase or fix. For example, participants at both locations recognize both the importance and the impossibility of neutrality and word-for-word translations. The impossibility of interpreting without transforming discourse and acting upon its structure has long been demonstrated by studies in linguistics (Wadensjö, 1998). Clinicians at both locations seem to have integrated this understanding into their practice. All participants also recognized that interpreters are not automatons; they must involve their subjectivity and prioritize meanings over literal translations. This representation is quite different from the one usually found in research on healthcare practitioners (Brisset et al., 2014; Leanza, 2008; Rosenberg, Leanza, & Seller, 2007) or interpreted healthcare interventions (Davidson, 2000; Leanza, 2005).

Participants recognized cultural informant, mediator, and cotherapist roles. Even outside the clinics, Paris interpreters are invited to share their knowledge at seminars and university courses. As mediators, interpreters become full interlocutors who create a bond of trust with both parties and who bridge gaps between worlds, languages, and cultures. Interpreters create this bridge by explaining the family's universe to clinicians. Clinicians consider this knowledge to be ethically and clinically desirable. Whereas Paris interpreters also reported the need to explain the clinicians' universe to the parents, allowing for mutual understanding and adjustment of expectations, the interpreters in Montreal appeared more prone to protect families from what they see as intrusive or inappropriate clinicians' interventions. This difference might be due to the short history of the Montreal clinic as a formal structure. In the Montreal clinic clinicians seem to have developed their own individual ways of working with interpreters, but the clinic as a whole lacked a common framework. This might explain why the clinic did not provide training to enable interpreters to understand the therapeutic process and diverse clinician behaviours. In both locations, one interpreter fulfills the role of coordinator; she serves as a bridge between interpreters and the clinical team to facilitate interpreter integration. This coordinating role seems to be more developed and efficient in Paris, perhaps because it has existed for a longer period.

The role of cotherapist can only appear within a defined framework. For example, clinicians in Raval and Smith's study (2003) who wished for interpreters to take a cotherapist role, reported elements that prevented this, including: clinicians' fear of losing control; lack of time and continuity; role ambiguity; and power differentials between clinicians and interpreters. However, from the experience of the Paris clinic, we have learnt that the passage from translator to cotherapist is possible within a defined framework, which includes the positive elements we discussed above. For some interpreters, the adoption of the cotherapist role is facilitated by the fact that they are also clinicians.

In the end, clinicians must find a balance between providing structure for the interpreter and allowing flexibility so that everyone can do their work. Both clinics seem to have developed a model similar to the *restricted interactive model* of cooperation described by Bot (2005). This includes the rules interpreters must follow in order to remain close to interlocutors' discourse, but also implies that the interpreter is considered as a whole person who has to deal with complex translation issues. The model developed in both clinics gives voice to the interpreters, but clearly frames their activity. This framework includes recognition of role ambiguity and the necessity of flexibility in role management. Such a framework is also important to prevent interpreters from finding themselves in situations in which they are asked to take on roles that go beyond their expertise (Darling, 2004; Raval, 2005).

While adherence to a common framework is a key characteristic of a positive working alliance, the nonintegration of interpreters into a common framework may increase transgression of (implicit) limits and/or negative feelings for both interpreters and clinicians (e.g., mistrust or powerlessness). Results also indicated that the lack of a common framework prevents interpreters from setting limits with families. In Paris, interpreters have access to supervision and support. The absence of such support can affect interpreters' well-being and their work as reported by Montreal interpreters, who principally rely on their spouse for "debriefing." Loutan, Farinelli, and Pampallona (1999) insist on clinicians' responsibility to be aware of interpreters' well-being and to provide the necessary support or direct them to appropriate resources. Clinicians are the healthcare professionals in the room, and should use their clinical skills to evaluate interpreters' levels of need. However, managers can also play an essential role in providing the necessary resources for professional development as Raval (2005) points out. This means that interpreters need to be considered as part of the clinical team, by managers as well as clinicians.

Interpreters in child and adolescent mental health

The results of this study do not provide great insight into the issues in working with interpreters in child and adolescent mental healthcare. One reason for this is that most children and adolescents are bilingual (as they are schooled in the host country's language) and hence their individual consultations usually are held without

interpreters. Nonetheless, our results reveal three important elements of the interpreter–child/adolescent interaction in such context.

First, the presence of children influences the interpreter. In Paris and Montreal, interpreters translate more for parents since children are often bilingual, but interpreters pay more attention to the quality of the translation when bilingual children are present to monitor it. Compared to Montreal interpreters who interact and create a bond with children (they speak directly to them and play with them when therapy requires it), Paris interpreters report little interaction with them, probably because the setting is more oriented toward the family as a unit. As such, there may be more interactions among adults (clinicians and parents) than between adults and children.

Second, the presence of interpreters offers opportunities for mediation between parents' expectations and the institution. Parents may lack knowledge on what they can expect from mental health services (Loshak, 2002), and interpreters can help in this regard. However, this role of the interpreter is not specific to interventions with children and adolescents. Interpreters may also allow mediation between children and their parents about differences in values between generations. Moreover, family organization can be undermined as a result of different rates of integration of parents and children into their new place of residence (Hodes, 2002). In this context, the process of translation can restore parents' authority and calm relationships in the family. A treatment that empowers parents is likely to be beneficial for the child (Loshak, 2002).

Third, according to participants, children's identification with the interpreter may help them to restore their self-esteem and integrate their two worlds. Children may also be relieved that someone other than them translates for their parents. Children should not be given this responsibility, as stressed by the existing literature (Ehnholt & Yule, 2006; Loshak, 2002; Raval, 1996; Rousseau et al., 2011). The presence of an interpreter also gives children the opportunity to speak in the language of their choice.

Limits and future research

This study has important limitations. We examined only two clinics, which were chosen for their expertise in transcultural healthcare, making them atypical of the whole healthcare system. Moreover, the clinics differed in many ways. The Montreal-based clinic is considered a primary care center, while in Paris the clinic provides specialized care. The staff of the two clinics have different gender mixes, as well as cultural and national backgrounds, with the Paris team being more diverse than the team in Montreal. The care process is also differently organized with Paris using a group of clinicians, while Montreal uses a duo. The impact of these differences on interpreters' integration might be explored further with an ethnographic approach; similar studies in other specialized clinics and locations would complement our results. As the clinic directors were involved as coresearchers, team members might not have felt free to reveal some aspects of their

experience, especially regarding power struggles. However, the principal investigator and his research assistant (YL & IB), who conducted the interviews, did not have any link with the participants before the research was undertaken.

Interpreters working in different healthcare settings may be an invaluable resource for future research. Their understanding of various healthcare practices could help in formulating more specific recommendations. Having interpreters compare their own work across different settings could help researchers identify specific challenges and opportunities in work with interpreters in different healthcare settings. Cross-national comparisons are still rare in the field. These might enhance our understanding of interpreted healthcare dynamics by illuminating what can be considered “universal” and what is specific to particular national or cultural contexts. According to participants, the presence of interpreters might have therapeutic effects on children and the child–parent dynamic, contributing to the therapeutic process. Testing this hypothesis is another important task for future research.

Another limitation of the present study is that it focused on discourse rather than practice itself. Most interpreting research is done using interviews, which is of course informative, but there is a well-known gap between discourses and practices. More observational studies are needed as underlined by Brisset et al. (2013). As observation of actual clinical consultation might be difficult to realize, so other methods should be used such as (video) vignettes or “difficult cases” to immerse clinicians, patients or interpreters in complex situations and grasp their representations and affects related to such situations. Sampling in other settings (e.g., residential settings, inpatient wards, juvenile protection/detention) might further develop these themes and identify new ones. In sum, a range of samples and methods would be most likely to provide a well-rounded understanding of interpreted child/adolescent mental health interventions, which could in turn help interpreters and clinicians develop knowledge, understanding, skill, mutual appreciation, and optimal clinical outcomes.

Conclusion

This research project was original in at least three aspects, involving (a) a transatlantic comparison (b) of specialized mental health clinics (c) for children, adolescents and their families. Despite this originality our results are consistent with past literature, confirming core results on diversity of interpreters’ roles, the crucial places of trust and time, need for recognition of interpreters’ and the complexity of practitioners’ work.

While authors do not agree on whether interpreters should translate literally or play more extensive roles in mental health (Bauer & Alegria, 2010), there appears to be consensus on the complexity of interpreters’ work when they are asked to play more extensive roles, as in the clinics chosen for this study. Recognition of the fundamental ambiguity of their roles and laying aside (or positively managing) clinicians’ need for control might lead to better practice and health outcomes.

The key challenge seems to be the collaborative building of an integrative framework. This favours a work climate characterized by trust, mutual understanding, and valorization of everyone's contributions to the therapeutic task. Nonetheless, integration in a clinical team, as in the larger society, is a slow process that requires space for reflection in order to build a common framework. Interpreters need to acculturate, like immigrants to the society, to the clinical milieu in order to offer professional services. The interpreter must understand what being a professional within these teams means and transmit this understanding to patients, while being culturally appropriate. Interpreters' integration within clinical teams is a metaphor for integration within society: differences and *métissages* may exist within a framework (laws) respected by all.

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Notes

1. Participants' identification codes: C = clinician, Int = interpreter, followed by participants' number and then P = Paris and M = Montreal.
2. According to the standards of qualitative research, quotations have been edited while preserving participants' intended meaning. Adjustments relate to hesitations, repetitions and verbal idioms. The interviews were conducted in French. Excerpts were translated by the first author and verified by the second.

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