Therapeutic Alliance in Interpreter-Mediated Psychotherapy from the Perspective of Refugee Patients: Results of Qualitative Interviews

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Keywords

Interpreter · Psychotherapy · Refugees · Therapeutic alliance · Trust

Abstract

Background: The therapeutic alliance is considered to be one of the most important factors of psychotherapy and is a necessary requirement for a successful treatment in interpreter-mediated psychotherapy. **Patients and Methods:** Using interpreter-mediated guided interviews, 10 refugee patients who experienced interpreter-mediated psychotherapy were asked about factors influencing the development of a trusting therapeutic alliance in the triad. The analysis of the interviews followed the rules of content-structuring qualitative content analysis. **Results:** A total of 11 factors were identified which could be assigned to the interpreter, therapist, or patient. In the analysis, the central role of the interpreter in establishing a therapeutic alliance in the triad became particularly clear. **Conclusions:** Consideration of the factors that, from the patients' perspective, influence the establishment and maintenance of a trusting alliance within the triad, as well as the recommendations for action derived from this for psychotherapists and interpreters can lead to an improvement in the therapeutic treatment of refugees.

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Die therapeutische Beziehungsgestaltung in der dolmetschergestützten Psychotherapie aus der Perspektive geflüchteter Patienten: Ergebnisse qualitativer Interviews

Schlüsselwörter

Dolmetscher · Psychotherapie · Geflüchtete · Therapiebeziehung · Vertrauen

Zusammenfassung

Hintergrund: Die Therapiebeziehung gilt als einer der wichtigsten Wirkfaktoren der Psychotherapie und ist auch in der dolmetschergestützten Psychotherapie für eine erfolgreiche Behandlung notwendig. **Patienten und Methoden:** Mittels dolmetschergestützter Leitfadeninterviews wurden 10 geflüchtete Patienten, die eine dolmetschergestützte Psychotherapie in Anspruch genommen hatten, zu Faktoren befragt, die den Aufbau einer vertrauensvollen therapeutischen Beziehung in der Triade beeinflussen. Die Auswertung der Interviews folgte der inhaltlich strukturierenden qualitativen Inhaltsanalyse. **Ergebnisse:** Insgesamt wurden 11 Faktoren identifiziert, die sich dem Dolmetscher, Therapeuten oder Patienten zuordnen ließen. Deutlich wurde die zentrale Rolle des Dolmetschers für die therapeutische Beziehungsgestaltung in der Triade. **Schlussfolgerungen:** Die Berücksichtigung der Faktoren, die aus der Sicht der Patienten die

sichtigung der Faktoren, die aus Perspektive der Patienten den Aufbau und die Aufrechterhaltung einer vertrauensvollen Beziehung in der Triade bedingen, sowie der daraus abgeleiteten Handlungsempfehlungen für Psychotherapeuten und Dolmetscher kann zu einer Verbesserung der therapeutischen Behandlung von Geflüchteten führen.

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Introduction

Interpreter-mediated psychotherapy has become an increasingly important treatment option and research topic in recent years in light of the approximately one million refugees who arrived in Germany between 2015 and 2017, their increased vulnerability to mental health problems such as posttraumatic stress disorder and other trauma-related disorders [Lindert et al., 2018; Kien et al., 2018], lack of language skills, and a shortage of multilingual psychotherapists [Baron and Flory, 2016]. Initial studies from Germany, Denmark, and the USA, in which psychotherapists, interpreters, and patients were interviewed on the topic of interpreter-mediated psychotherapy, show that a trusting alliance between all parties is perceived as essential for the success of the treatment [Miller et al., 2005; Mirdal et al., 2012; Hanft-Robert et al., 2018]. The therapeutic alliance has long been the focus of psychotherapeutic research. It is considered one of the most important factors influencing psychotherapy, operates across all forms of therapy, and is implicit in the context of every therapeutic interaction [Orlinsky et al., 1994]. The therapeutic alliance appears to be much more complex and multifaceted in triadic psychotherapy compared to dyadic psychotherapy [Tribe and Thompson, 2009; Brisset et al., 2013].

The Therapeutic Alliance with the Addition of an Interpreter

The term “therapeutic alliance” generally refers to both the personal alliance, which is based on interpersonal and affective aspects such as sympathy and understanding, and the task-oriented alliance, which involves joint work on therapy goals and tasks [Hougaard, 1994]. In a classic dyadic setting, the formation of the therapeutic alliance depends on patient-therapist interaction and is essentially described as the ongoing task of the therapist [Sachse, 2016]. Empathy, unconditional positive regard, and genuineness, therapist variables stemming from client-centered psychology, are considered vital elements of a good therapeutic alliance, regardless of the form the therapy takes [Schnell, 2014]. In a setting involving an interpreter, however, the therapeutic alliance is no longer determined solely by the therapist and patient, but also

largely by the interpreter [Miller et al., 2005; Tribe and Thompson, 2009; Mirdal et al., 2012]. Pugh and Vetere [2009] interviewed psychotherapists working with interpreters and showed that due to the linguistic and cultural proximity between patient and interpreter and indirect communication via the interpreter, traditional conceptualizations of empathy involving the psychotherapist at the center of the empathic alliance were difficult to transfer to interpreter-mediated psychotherapy. Interviews with psychotherapists also revealed that the feeling of being under observation as well as the worry about loss of control could have an unsettling effect on the psychotherapist, especially at the start of the triadic collaboration [Metzner et al., 2018]. The cultural and linguistic proximity of the interpreter to the patient can often lead to the therapist feeling excluded or superfluous and can make it feel more difficult to build a relationship with the patient [Miller et al., 2005; Tribe und Thompson, 2009; Mirdal et al., 2012]. Besides the organizational effort and unclear financing of interpreter costs, the fear of an impaired patient-therapist relationship is one of the primary reasons that some psychotherapists are critical towards the idea of collaborating with an interpreter or may even reject it altogether [Miller et al., 2005; Morina et al., 2010].

Refugees as a Special Patient Group

Due to the language barrier, the psychotherapeutic care of refugee patients is a common field of work for interpreters. In intercultural settings, various concepts of illness, communication styles, ideas about “therapy,” and expectations these bring can hinder the therapeutic alliance [Qureshi and Collazos, 2011; Schouler-Ocak and Aichberger, 2017]. Cultural sensitivity is therefore required of the therapist [Qureshi and Collazos, 2011; Schouler-Ocak and Aichberger, 2017]. The interpreter can act as a cultural as well as linguistic mediator in order to clarify cultural misunderstandings and foster mutual understanding [Miller et al., 2005]. Compared to psychotherapy with nonrefugee migrants, it must be taken into consideration that refugee patients have frequently had extreme or even traumatizing experiences before and during their escape, which can complicate the trust-building process with a therapist [Erim and Morawa, 2016]. This can then lead to feelings of mistrust towards the interpreter, particularly if they have been subjected to violence by compatriots and associate the interpreter with these experiences, or if they have ethical, religious, or political concerns [Tribe and Morrissey, 2003; Metzner et al., 2018]. In addition, living conditions in the host country of refuge and any uncertainties that accompany this, such as an unsecured residence status, can complicate the therapeutic work and the development of a stable therapeutic alliance in psychotherapy with refugees [Thöle et al., 2017]. In initial studies comparing psycho-

therapy with and without the use of interpreters in refugees with posttraumatic disorders in Sweden, the UK, and Germany, the effectiveness of interpreter-mediated psychotherapy did not differ from that of classic dyadic psychotherapy [D'Ardenne et al., 2007; Brune et al., 2011]. However, hardly any studies could be found that examined the influence of interpreters on the therapeutic alliance. Although many studies emphasize the importance of a good therapeutic alliance in the triad [e.g. Miller et al., 2005], there has seldom been an explicit examination of the challenges that emerge and of how a trusting alliance in the triad can succeed. Moreover, studies on triadic psychotherapy from the viewpoint of the patients [e.g., Mirdal et al., 2012] are largely lacking. The current study therefore aimed to identify factors that are required for building and maintaining a trusting therapeutic alliance in the triad from a patient perspective.

Methods

In a qualitative study, refugee patients in Northern Germany were interviewed about trusting therapeutic alliances in interpreter-mediated psychotherapy by means of open-ended, semistructured guided interviews and with the help of an interpreter. The study was reviewed and approved by the local ethics committee of the Faculty of Psychology and Movement Science at the University of Hamburg (case No. 2018_164). The interview guide was developed by S.H.-R. and F.M. The interviews were carried out by S.H.-R. Analysis of the interview data was carried out by S.H.-R. in cooperation with N.J.P. S.H.-R. has a BSc in Psychology and has already conducted research on interpreter-mediated psychotherapy with refugees [Hanft-Robert et al., 2018]. She has experience in both conducting guided interviews and qualitative data analysis [Hanft-Robert et al., 2018]. F.M. is a psychologist (German: Dipl.-Psych.) and is conducting research as a research assistant on topics such as interpreter-mediated psychotherapy and the mental health of refugee minors [Metzner et al., 2018]. N.J.P. is a psychologist (German: Dipl.-Psych.) and postdoctoral researcher. She has extensive experience conducting and analyzing qualitative interviews (example research interests: potentially inadequate medication, somatoform disorders [Pohontsch et al., 2018]). C.U. is a psychological psychotherapist and trauma therapist (DeGPT) for children, adolescents and adults and specializes in the therapeutic care of refugee patients [Reher and Metzner, 2016]. A.R. is a professor of educational psychology (example research areas: communication, cooperation and conflict in social groups, secondary traumatization among interpreters in the care of refugees [Wichmann et al., 2018]).

Study Participants and Recruitment

The interviewees were selected according to predetermined criteria. The study included adults aged 18 and above who had fled to Germany from non-EU countries and were receiving interpreter-mediated psychotherapy at the time of the interview or had done so a maximum of 3 months beforehand. On the basis of the 5 probationary sessions that usually precede psychotherapeutic treatment in which, inter alia, patient-therapist compatibility is clarified and the establishment of a trusting therapeutic alliance initiated, the interpreter-mediated therapy must have taken place at least 5 times.

The interviewees were recruited through their psychotherapists. Northern German institutions and bodies specializing in the psychotherapeutic treatment of people with a migration or refugee background were contacted for this purpose. In addition, psychotherapists in private practices offering the special service of "treatment with interpreter" in the search portal of the chamber of psychotherapists in Berlin, Bremen, Hamburg, Lower Saxony, Saarland, and Schleswig-Holstein (<http://www.psych-info.de/>) were contacted. Practitioners were asked for potential interview partners and informed eligible patients about the study. Interested patients received both verbal and written information about the aim of the study and had the opportunity to ask questions about it. All interviewees provided fully informed consent to participate in the interview, to the recording of the interview, and to the further processing of the interview data.

Interpreters for the interviews were acquired through interpreting services and psychosocial institutions in northern Germany. Only interpreters with experience in the medical or psychosocial field were chosen. To avoid potential distortion tendencies, no interpreters who interpreted in the therapy sessions of the participating patients were used. Before the start of the interview, the interpreters were informed verbally that the conversation would be confidential and that medical confidentiality would be observed.

Sample Description

A total of 10 refugee patients ($n = 4$ females) were interviewed, ranging in age from 18 to 61 years old (median = 34 years), who had fled to Germany 2.5–6.5 years ago (median = 3 years). They came from Afghanistan ($n = 3$), Syria ($n = 2$), Iran, Iraq, Kurdistan, Chechnya, and Ingushetia ($n = 1$ each). With the exception of 1 person whose psychotherapy had ended 1 month before the interview, each of the interviewees had been receiving interpreter-mediated psychotherapeutic treatment from the same psychotherapist for 0.5–3 years (median = 1.5 years) at the time of the interview. All psychotherapists were trained in behavioral therapy but applied a range of stabilizing and trauma-focused methods.

Interview Guide

The Problem-Centered Interview (PCI) by Witzel [2000] was chosen as a qualitative survey instrument. The PCI is centered on a previously determined and analyzed socially relevant problem [Witzel, 2000], which in the case of this study is the trusting therapeutic alliance as an essential component of successful interpreter-mediated psychotherapy with refugees. Concerning knowledge acquisition, the PCI involves a deductive-inductive interplay [Witzel, 2000]. On the one hand, the interviewees should talk about their subjective experiences as freely as possible, thereby enabling them to explore new insights. On the other hand, the researcher acquires theoretical prior knowledge during the initial problem analysis that can be explicitly addressed and thus verified in the interviews. The application of the PCI is enabled and supported by an interview guide, an audio recording, a short questionnaire, and a postscript [Witzel, 2000].

The interview guide was designed by S.H.-R. and F.M., according to Helfferich's SPSS approach [2011]. This involves collecting aspects that are relevant to the research question, reformulating these aspects into questions and then checking to what extent they allow for open-response behavior. The questions are arranged into a sequence that is logical in terms of content and time, grouped into thematically related bundles of questions, and subsumed under an overarching, narrative-inducing question [Helfferich, 2011]. The interview guide contained three open-ended, narrative-inducing questions, with prompts to talk in a broad way about psychotherapy with interpreters, the therapist, and the interpreter. During the initial problem analysis, the aspects of division of roles,

accuracy of translation, and continuity of all participants were identified as possible factors influencing the therapeutic alliance. These were then reformulated into questions and subsumed under the narrative-inducing questions. Other subsumed questions aimed at eliciting aspects that promote as well as hinder the development of a trusting relationship. After the first interview, the guide was critically reviewed, and minor adjustments were made.

Conducting and Transcribing the Interviews

The interviews were conducted by S.H.-R. based on the previously created interview guide. The guide allowed for flexibility to enable the interviewer to deviate individually from the prewritten questions in order to elicit new or unexpected topics from the interviewee [Kvale, 2007]. The interviews were conducted between May and June 2018 with the help of an interpreter. They took place either at the premises of the psychotherapists through whom the interviewees were recruited or at the interviewees' homes and lasted between 50 and 80 min. The patients received 20 euros as remuneration. The interpreters were paid 30 euros per hour. All interviews were recorded digitally. A postscript was produced after each interview. The audio recordings of the interviews were transcribed by S.H.-R. according to the simple transcription system of Dresing and Pehl [2018]. The transcripts were compared again with the audio recording by S.H.-R. and thereby checked for accuracy.

Data Analysis and Quality Criteria

The aim of the study was to identify content-related aspects to answer the research question. Data analysis followed the rules of content-structuring qualitative content analysis according to Kuckartz [2016]. This enables the content to be summarized and data to be structured by means of a category system consisting of main categories and subcategories [Kuckartz, 2016]. The interview data were analyzed by S.H.-R. in cooperation with N.J.P. using MAXQDA qualitative data analysis software.

Following Kuckartz [2016], the structuring content analysis started with initiating text work, which includes reading important text passages several times and marking them. Based on this, initial main categories were formed inductively and used to code all of the data material. The aspects identified during the problem analysis (division of roles, accuracy of translation, and continuity of all participants) were assigned to the corresponding main categories as deductive subcategories. The first coding process was followed by the compilation of all text passages coded with the same category and a further differentiation of the relatively general main categories through the inductive formation of subcategories. Finally, all data material was coded twice more using the differentiated category system to ensure that no important aspects were overlooked. The anonymized interview data, the codes and the category system developed were discussed in an independent research group to ensure the intersubjective comprehensibility of the data analysis.

Results

Based on the interview data and with the help of the structuring content analysis, 11 aspects (subcategories) could be identified that influence the establishment and maintenance of a trusting therapeutic alliance between all participants in interpreter-mediated psychotherapy from a patient perspective. These could be assigned to the interpreter, the psychotherapist, or the patient (main categories).

Factors Relating to the Interpreter

The Interpreter as a Bridge of Communication with the Therapist

All interviewees emphasized that due to the language barrier, psychotherapy would not be possible without an interpreter, and therefore a trusting relationship with the interpreter was a basic requirement for starting treatment. The interpreter was described as bridging the communication gap with the therapist, enabling the patient to express him or herself verbally, understand the psychotherapeutic support, and build a relationship with the psychotherapist: "The interpreter is like a bridge, establishing contact between me and the therapist" (IP-04).

Accurate Translation on a Linguistic and Emotional Level

All interviewees stated accurate translation as a key task of the interpreter and a prerequisite for building a trusting alliance in the triad. This was referred to firstly on a linguistic level, as the interpreter requires very good proficiency of both languages that converge in therapy. However, all of the interviewees also highlighted the importance of accurate translation on an emotional level, which required the interpreter to have a level of emotional understanding: "I generally wonder how the therapist can understand me precisely, completely, understand every single thing about me, if the interpreter can't understand me well? It always starts with the interpreter" (IP-06). Interviewees reported knowing how accurate the translation was by the extent to which the therapist's translated response matched what they were saying. One interviewee mentioned feelings of powerlessness and helplessness as well as reduced motivation for therapy as a result of what he perceived as a poor translation: "Well, it always upset me that the things I said weren't relayed in the way I told them. [...] You feel kind of powerless too, because you can't say these things yourself. [...] When I see that my words haven't been relayed correctly to the therapist, I realize that I've lost interest, and then I ask myself why I'm even here, and at that point the therapy becomes pointless" (IP-10). Two interviewees described how direct questions from the interpreter in case of ambiguities regarding the translation were helpful. This increased trust in the translation service and thus trust in the interpreter him- or herself.

Impartial Appreciation and Compassion

All interviewees mentioned displays of appreciation and compassion on the part of the interpreter as factors that strengthened the relationship. Visible disinterest and lack of concentration in the therapy session were viewed negatively: "In the beginning, the interpreter wasn't always that committed. Sometimes he was busy, sometimes he didn't come. He wasn't that involved in my therapy, he

didn't always stay in touch with me. That wasn't great" (IP-06). Three interviewees recounted a negative experience whereby the interpreter personally interfered in therapy and cited the impartiality of the interpreter as necessary for them to speak without fear: "Well, I had a bad experience once. I said something to the translator and [...] the interpreter interfered and didn't translate what I said. He wanted to assert his own culture and not translate what I had said. [...] If I say, for example, I'm not Muslim and the interpreter is Muslim, then he's not allowed to take sides or interfere – he has to stay neutral. The interpreter's own emotions shouldn't play any role in psychotherapy" (IP-09).

Presence of a Second Unknown Person

Eight interviewees described wanting to have psychotherapy without an interpreter, especially at the start of therapy. The presence of a second unknown person made it difficult for them to establish trust and share very personal, intimate experiences, and took some time to get used to: "There were some things I didn't want to discuss with anyone and then both the therapist and the interpreter were there, two people I had to talk to [...] and the more people are present, the harder it is [...]. At the start I felt like we could discuss my situation better if there were just two of us – when it's private, you only want to have to tell one person" (IP-04).

Lack of Professionalism

One factor that hindered the trust-building process with the interpreter at the beginning of therapy was a perceived lack of professionalism and accompanying uncertainty about how well trained the interpreter was to work in a psychotherapeutic setting: "You see this person [the therapist] as a professional whose job it is to make you better. You can trust this person straight away. This person wants to help you rather than harm you. But with the interpreter, it's different" (IP-08). All interviewees considered the information that the interpreter is also bound to professional secrecy to be a basic requirement for speaking openly in therapy: "I had the feeling that there was a small gap, that something could get out through the interpreter. But after I was instructed that the interpreter is bound to secrecy too, that he has to keep everything that is discussed here in this room, I could slowly start to trust him" (IP-10).

Four interviewees expressed the desire that not only the therapist, but also the interpreter possess background knowledge in psychotherapy, since the interpreter greatly influences the treatment: "I think that the interpreter should have experience with psychotherapy. It's not just about having good language skills. In psychotherapy there's a lot of talking and recounting. These processes, which take place between me and the psychotherapist,

have to be understood and steered by the interpreter. The interpreter not only needs good language skills, but also specific experience in this field, in psychotherapy" (IP-10).

Continuous Presence

After a period of acclimatization, the interviewees considered the interpreter to be an integral part of the therapy, similar to the therapist. They felt it was important for the same interpreter to be present on a continuous basis and familiar with the therapy and topics being worked on. Frequent change was an obstacle to an atmosphere of trust in the triad, as trust always had to be built again from scratch: "I said I only wanted one interpreter [...] and I didn't want a new one every time. Then I would have to say everything all over again. I don't want to have to trust a new person every time. You could put it like this: I go to a therapist and talk to one therapist, and that's how it is with the interpreter too, it makes me feel good. I always do therapy with one therapist and one interpreter" (IP-02).

Factors Relating to the Psychotherapist

Creating a Clear Division of Roles when Working with an Interpreter

All interviewees saw the therapist as the most important person of reference and the one responsible for the treatment from the outset. They described it as positive that the division of roles, which involved the interpreter in the background and the contact between therapist and patient in the foreground, was communicated to all participants in a clear and transparent way by the therapist. In terms of the practical implementation of this division of roles, it was considered helpful when the interpreter and therapist acted as a treatment team, with both therapist and interpreter pointing out the division of roles to the patient during the therapy session: "My therapist said, 'You're here to see me, so we'll look at each other, and the interpreter is just there to help us understand each other's words' [...]. Later on, the interpreter helped, when I looked at her she always signalled to me that I should look at the therapist, she nodded like this with her eyes and head towards the therapist. [...] That was the interpreter. Outside I could talk to her, but inside, when I asked her something, she always said, 'You're here with the therapist, ask her, look at her' and translated everything and didn't answer me directly. And later I gradually stopped talking to the interpreter. Maybe it's experience, yes, experience, which is important on the interpreter's part. She's the one who taught me that, and it helped me so very much" (IP-04).

Nonverbal Expression of Appreciation, Compassion, and Understanding

When asked which attributes or behavior from the therapist could help establish a relationship of trust with them, all interviewees referred to feelings of appreciation,

compassion, and deep understanding. Since direct, verbal communication with the psychotherapist was generally not possible due to the language barrier, three of the interviewees highlighted the importance of nonverbal expression: "I've learned from experience to watch the therapist to see if she can see and grasp my problems, I can see it in her face. Every now and again it doesn't matter if you don't understand the language. It's the facial expressions and appearance, gestures, that say so much" (IP-09). One interviewee stated that despite indirect communication through the interpreter, direct eye contact strengthened the relationship with the therapist, as the latter could see the interviewee's facial expressions and thus his emotions.

Sensitivity to Patient-Interpreter Compatibility

Particularly at the start of therapy, sensitivity to patient-interpreter compatibility as well as the active questioning and clarification of discrepancies were stated as positive. For example, one interviewee reported already having a little knowledge of German: "When the interpreter left, the therapist told me she felt I wasn't speaking that openly and asked me if I would like another interpreter. And then I had the courage to be honest about what I didn't like. [...] The next time, we discussed the issue together with the interpreter, I mentioned what I was feeling and calmed down" (IP-04). This also included clarifying to what extent the gender of the interpreter played a role for the patient: "The therapy is often about very private things, intimate things, and I don't want a man to be there. I said straight away that a woman should be there" (IP-01).

Factors Relating to Patients

The Patient's Life Story

According to four of the interviewees, the development of trust in the triad was influenced by their own life story and in connection with this, their basic ability to trust. For example, one interviewee described having suffered severe discrimination and persecution in the past and having experienced a number of breaches of trust in this context: "I had problems before, trusted someone, and then still had problems. I had a very hard time trusting others. I was always scared other people would come to me and want to kill me. And when these things keep entering your mind, it's difficult to trust others. You need a bit of time" (IP-02).

Lack of Knowledge about the Concept of Psychotherapy

Half of the interviewees reported being rather suspicious of treatment initially due to a lack of knowledge about the concept of psychotherapy: "At first, because I hadn't seen or heard of psychotherapy before, it was very foreign to me and I had a lot of reservations about wheth-

er psychotherapy could even help me. And when I was in psychotherapy, I realized that the people wanted to help me rather than harm me. And over time I trusted them more and then I could really participate in the therapy, then the therapy helped me" (IP-08). When asked how the feeling of trust developed over the course of therapy, two interviewees reported fears of being stigmatized as crazy due to psychotherapy. This fear had to be overcome in order to get involved in the treatment and engage with the therapist and interpreter: "In Afghanistan, no one does these things – when someone goes to therapy with a therapist, we say this person is 'crazy.' That's not normal in Afghanistan" (IP-02).

Discussion

In this study, patients were asked about factors that have an influence on the therapeutic alliance in psychotherapy with a third party. The results provide initial indications of the challenges that may be involved in forming alliances in interpreter-mediated psychotherapy. In addition, they provide information about aspects that facilitate the establishment and maintenance of a trusting relationship in the triad from the patients' perspective and enable recommended actions for therapists and interpreters (Table 1).

A trusting alliance with both the therapist and the interpreter was described by all the patients interviewed as a basic prerequisite for treatment, which is consistent with the existing literature [Miller et al., 2005; Tribe and Thompson, 2009; Mirdal et al., 2012]. The interpreter can be understood as bridging the linguistic-emotional communication gap with the therapist, enabling the patient not only to speak in his or her native language, but also to build a relationship with the therapist. While the existing literature frequently states the interpreter's language skills and a translation that is as verbatim and complete as possible as essential criteria for successful treatment involving a third party [Hadziabdic et al., 2014], the patients interviewed in this study emphasized the importance of the interpreter's emotional understanding and the translation of the patient's feelings. The interpreter first has to understand what is said on an emotional level before he/she can pass it on to the therapist in such a way that the therapist can really understand and provide assistance to the patient. If the translation service is perceived as inadequate due to a discrepancy between what the patient says and the therapist's reaction, this can lead to feelings of powerlessness and helplessness on the part of the patient, as well as to a reduced motivation for therapy. This underlines how much of a risk is posed by using lay interpreters, which involves an increased likelihood of a poor translation service [Flores, 2005].

Table 1. Recommended actions for interpreters and psychotherapists for forming a trusting therapeutic alliance in the triad

Interpreter	<ul style="list-style-type: none">– Be aware of one's own central role as a linguistic-emotional communication bridge between patient and therapist– Comply with the medical confidentiality– Help the patient observe the division of roles (e.g., indicate to the patient to look at the therapist despite indirect communication)– Very good skills in both languages and accurate translation– Emotional understanding– Inquire directly in case of uncertainties regarding the translation– Treat the patient with appreciation and empathy– Impartiality, avoid interfering on a personal level– Acquire psychotherapeutic background knowledge– Continuous presence
Psycho-therapist	<ul style="list-style-type: none">– Give the patient time to get used to the situation with a third person, clear up issues of mistrust if necessary– Actively question interpreter-patient compatibility, jointly clarify possible disagreements if necessary, or change the interpreter– Avoid the use of lay interpreters– Inform the interpreter about compliance with confidentiality rules and his or her role in the triad before therapy starts– Agree with the interpreter upon how to communicate the division of roles to the patient– Explain the division of roles to the patient in the therapy session, emphasizing the therapist-patient relationship– Maintain direct eye contact with the patient– Increased nonverbal expression of appreciation, compassion, and understanding– Take the life story of the refugee patient into consideration with regard to building trust– Provide detailed information about the Western concept of psychotherapy; if necessary, inquire about and broach the issue of the fear of stigmatization

All patients stated the continuous presence of the same interpreter throughout the whole course of therapy as helpful for a trust-based collaboration in the triad, in addition to a clear division of roles communicated to all participants, with the therapist-patient relationship at the center. Across all the existing literature, an unclear division of roles and the resulting diffusion of roles are described as risk factors for successful treatment in a triad [Morina et al., 2010; Storck et al., 2016]. The results of this study show the importance of a well-established collaboration between therapist and interpreter, in which the interpreter is aware of his or her role and can thus actively help the patient stick to his or her role too.

In contrast to studies that describe the risk of incorrect dyad formation between interpreter and patient due to cultural and linguistic proximity [Pugh and Vetere, 2009; Tribe and Thompson, 2009; Morina et al., 2010], in this study the psychotherapist was perceived by all patients to be the most important person of reference from the outset, despite indirect communication through the interpreter. Nonverbal expression of appreciation, understanding, and compassion from the therapist made it easier for the patient to build a relationship with the therapist. As stated by other authors, direct eye contact between therapist and patient can be a simple method for strengthening their relationship [Searight and Searight, 2009]. Interviews with psychotherapists also demonstrated that translation should take place in the first-person form in order to clarify the division of roles and to strengthen the

patient-therapist relationship [Hanft-Robert et al., 2018]. In line with Brune et al.'s [2011] recommendation that the interpreter should adopt a neutral but empathic attitude, the patients rated an appreciative, empathetic manner with a simultaneous personal impartiality on the part of the interpreter as trustworthy.

Similar to psychotherapists and interpreters [Hanft-Robert et al., 2018], patients also require a period of acclimatization in a triadic setting. At the start of therapy in particular, the presence of the interpreter was described as necessary due to the language barrier; however, it was also described as disrupting the trust-building process. The patients found it difficult to have to recount personal and intimate experiences to two strangers. In addition, the suitability of the interpreter for the therapeutic setting and compliance with confidentiality rules were initially doubted. From the patients' perspective, background knowledge in psychotherapy would increase the trustworthiness of the interpreter. Interviews with psychotherapists have also shown that an understanding of psychotherapy on the part of the interpreter would improve collaboration and treatment [Hanft-Robert et al., 2018].

The results of this study indicate that in psychotherapy with refugees, the trust-building process can generally be complicated by personal life story, lack of knowledge about the Western concept of psychotherapy, and the cultural fear of being stigmatized as crazy due to mental illness. This is consistent with the results of studies on intercultural psychotherapy that demonstrate that the par-

ticipants often lack knowledge about the concept of psychotherapy and that mental illnesses are associated with stigmatization, discrimination, and taboo [Qureshi and Collazos, 2011; Schouler-Ocak and Aichberger, 2017].

When evaluating the results, it should be taken into account that the distortion tendencies that tend to accompany verbal statements and possible personal exaggeration and falsification of what was said by the interpreter could not be excluded. Nevertheless, using an interpreter made it possible to interview a group of people who have attracted little attention in research to date, but for whom the success of interpreter-mediated treatment is of the utmost importance. By selecting experienced interpreters, an attempt was made to minimize the risk of an incorrect translation. The atmosphere during the interviews was perceived as trusting and open. This was demonstrated by, for example, the fact that some of the patients also expressed critical aspects regarding their therapists, interpreters, and the concept of psychotherapy in a triad. The study participants interviewed formed a heterogeneous sample in terms of gender, age, origin, duration of therapy, and duration of stay in Germany, which

led to a large variation in aspects that influence the establishment and maintenance of a trusting therapeutic alliance in the triad from a patient perspective. Nevertheless, the patients interviewed in this study were exclusively people who were either currently undergoing psychotherapy with an interpreter or had done so in the past, and who agreed in principle with this form of therapy. To gain further insight, it would be important to interview persons who had either refused or discontinued psychotherapy with an interpreter in order to identify further aspects that influence the therapeutic alliance and thus the success of interpreter-mediated psychotherapy.

Statement of Ethics

All interviewees provided fully informed consent to participate in the interview, to the recording of the interview, and to the further processing of the interview data.

Conflict of Interest Statement

There is no conflict of interest on the part of the authors.

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