

# Intercultural encounters in counselling and psychotherapy – communication with the help of interpreters

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## Abstract

Treatment and rehabilitation of torture victims and persons traumatized by war or persecution can require working in an intercultural setting, as is the case when working with refugees and migrants. The following article offers practical advice for diagnostics, counselling and treatment of patients from other cultures who are not speaking the language of the therapist.

*Key words:* Torture victims, intercultural communication, interpreting, practical advice

Perception, feeling, thinking and modes of expression are influenced by culture and context. Values, social norms, the individual's attitude towards members of the group, meanings, patterns of thought and action are established in the interaction of the group, evolve with the historical and social context across generations and create internalised "maps of meaning".<sup>1</sup> These constitute sometimes conscious, though predominantly subconscious, references for the individual, his or her identity formation and development. Thus influenced, concepts of the self, the world and modes of interaction form a wealth of opportunity but also restrictions.<sup>2</sup> Breaches of norms are connected with feelings of guilt and shame. In a traumatic

situation, the culture specific frames of reference influence the evaluation of the event of the trauma itself, its interpretation and its consequences. The culturally shaped actual and anticipated reaction of the social environment significantly affects the course of trauma reaction and coping mechanisms.<sup>3</sup>

If women from traditional societies – where honour and shame are of paramount importance in the regulation of social standing and relations – have experienced rape or other forms of sexual violence, they frequently suffer from complex PTSD<sup>4</sup> with chronic processes sustained by collective-dysfunctional cognition.<sup>5</sup> Somatic pain develops as a consequence of a chain reaction of dissociation, intrusion, avoidance, anxiety/stress in connection with chronic muscular tension. At the same time the somatic pain is a non-verbal expression for the trauma, anxiety and depression, to communicate the suffering without revealing its source and to seek primary care from physicians.<sup>6</sup> The women know that having been dishonoured by sexual violence they might be ostracized or even killed. The tendency to keep these experiences secret in order to protect oneself and the extended family from loss of honour and marginalization, makes therapeutic access difficult and supports impunity of the perpetrators.

For diagnostics and therapeutic interventions the frames of reference as well as modes of thinking and behaviour underlying

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culturally bound interpretations need to be taken into account and researched individually. Symptoms and accompanying behavioural patterns may also be pronounced differently. Remarkably, for example, women from the former Yugoslavia and Kurdish women from rural areas in Turkey often exhibit psychogenic seizures.<sup>4</sup> These are particular manifestations of dissociative states (so-called dissociative seizures, ICD-10: F44.5)<sup>7</sup> or changes of consciousness resulting from agitation and hyperventilation.

Even though clusters of symptoms of PTSD occur across cultures, the interpretation of complaints, their classification and the understanding of illness are culturally differentiated.

Psychotherapy for migrants means coming in touch with people whose frames of reference can be different in some areas from one's own. This coming together requires openness to reflect on one's own frames of reference, the consciousness of one's own cultural and contextual constraints as well as the perception of and respect for culturally and socially determined differences and flexibility of perspectives. Psychological models based on western societies cannot be transferred without examination and adaptation for people whose socialisation happened in collectively oriented societies. Working with peri- and posttraumatic schemata requires an adaptation of the interventions under consideration of rooted, culturally determined attitudes as well as an adaptation to the level of education. Therefore, the societal, historic-political and the current social context of the traumatisation are also to be included in systemic consideration.

Since, as a therapist one is unlikely to have a thorough understanding of all cultures, one risks falling back on stereotypes that can

distort perception of the individual patient. That is why it has proven useful to approach the world of the patient with an attitude of respectful curiosity and engaged neutrality through circular questioning.<sup>8,9</sup> This approach also enables the therapists to reduce their position of power that is attributed to them by their professional and social standing.

#### Helpful elements for intercultural communication

- Openness and genuine interest toward the patient's cultural background
- Respect, observation of codes of courtesy
- Using great care when dealing with topics involving shame and taboos
- Learning about culturally divergent styles of communication/cultures of language, paying attention to indirect communication
- Inquiring about the meaning of words, figures of speech and metaphors
- Circular questioning, approaching the topic from different angles
- Clarification of misunderstandings, encouraging follow up questions
- Reflection on and transparency of one's own culture/culturally determined behaviour
- Dialogs about differences between the country of origin and the country of exile or different cultures within one country (this can lead to humorous discussions about observations of the patient in the current context)
- Transparency of the professional role and the therapeutic process
- Repeated stressing of the doctor-patient confidentiality (including also the interpreter). This also means to assure no communication to close relatives and friends of the patient
- Imagination and the courage to improvise (e.g. asking the patient to draw, visualisation using items of symbolic reference)
- Attentiveness to non-verbal communication

#### Verbal communication with interpreters

In most cases interpreters are part of the therapeutic or counselling setting when working with patients from other countries or cultural backgrounds.

Apart from enabling patient and therapist to communicate verbally, the interpreter also plays a major role in clarifying culture and communication specific questions; a resource that should be made use of in the form of a brief exchange after every session.

The interpreter has to be fluent in both languages, respectful and of a controlled empathetic posture. The role of the interpreter has to be clear to all involved. She or he has to be trained specifically.

The training of interpreters working in therapeutic contexts includes the instruction of the basics of:

- his or her role in the setting and the form of translation
- psychopathological symptoms in traumatized patients
- basics in therapy, therapeutic relationships and the methods that may be used
- meaning of specific medical/psychological terminology
- knowledge about the everyday reality of asylum seekers or displaced persons

The training should also include methods for the prevention of burnout and secondary traumatization. Even if the interpreter makes an effort to translate with utmost neutrality and with maximum accuracy, it can be assumed that his or her presence and person-ality will have an impact on the interaction.

Transfer and counter-transfer reactions occur in a triad: patient – interpreter – therapist.<sup>10</sup> The therapist needs to be constantly aware of this process and has to reflect on this together with the interpreter after the treatment session.

Psychotherapy with the assistance of interpreters always requires a clearly structured cooperation based on a distinct definition of function and role.<sup>11-13</sup> The therapist is

responsible for the structuring of communication, the course of the conversation and the therapeutic process. He or she also needs to protect the interpreter from extreme emotional stress, which might cause the interpreter to suffer the risk of secondary traumatization or burnout. To be able to monitor the dynamics of the triad a triangular seating arrangement is recommended. This type of seating illustrates the importance of partnership for successful communication.

Certain principles and rules have proven useful in the work with interpreters in psychotherapy. See the box alongside for more details.

After getting used to working with interpreters, most therapists do not experience this setting as being difficult or hindering the process of counselling or therapy. Working with patients coming from different cultural backgrounds is a challenge, but also a very enriching experience.

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### Rules for working with interpreters

- Working with professional, well trained interpreters (wherever possible with specific training for therapy settings and counselling situations).
- Relatives or friends should not be used. Much information would not be communicated and personal relationships could be affected.
- The interpreter signs a written statement concerning the doctor/patient confidentiality.
- Keeping impartiality.
- There should be no private contact between interpreter and patient, which also includes not giving the patient the interpreter's phone number.
- Before the first therapy session, there should be a preliminary talk where the therapist briefs the interpreter.
- At the first session introduction of the interpreter and explanation of the rules and how the communication will be conducted with therapist/interpreter/patient.
- The interpreter translates everything that is being said by the patient and therapist in the first person ("I cannot sleep, I have nightmares", "I understood that you are waking up out of horrible dreams", etc).
- The translation should be as literal as possible (this is very important, also when doing diagnostics with patients who need psychiatric care, especially when dealing with psychotic patients).
- Generally consecutive translation is preferred (an exception is simultaneous translation when working with specific techniques, e.g. EMDR or screening-technique when simultaneous translation is often perceived as stressful).
- The interpreter should not add or leave out anything.
- Everything said in the room is translated.
- If terms used in a translation lead to misunderstandings they should be clarified through retranslation.
- The patient has to be made aware that if there is relevant communication outside the therapy room between him or her and the interpreter, the therapist will be informed about the content of the conversation.
- The therapist should use short sentences and phrases and avoid abstract concepts as well as technical terminology.
- The therapist should take care to communicate appropriately to the patient's level of education and ability to abstract and not leave it up to the interpreter to adapt and explain.
- The therapist pays attention to the flow of the conversation and interrupts politely if the patient speaks for too long. He or she also allows for the interpreter to interrupt to ask a clarifying question.
- The therapist makes an effort to speak to the patient directly and to establish eye contact.
- The therapist is aware of non-verbal communication.
- Exchange after the therapy session between therapist and interpreter. Clarification of misunderstandings, cultural characteristics, methodological approach, triadic relationships and debriefing with the goal to relieve the interpreter.
- The interpreter attends supervision and uses opportunities for further training.

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