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The Dyadic and Triadic Therapeutic Alliance in Cross-cultural Health Care: The case of Hispanic American Patients

BOSS-PRIETO OLGA LUCIA

UNIL | Université de Lausanne

FACULTE DE SCIENCES SOCIALES ET POLITIQUES

INSTITUT DE PSYCHOLOGIE

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THESE DE DOCTORAT

présentée à la
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Pour l'obtention du grade de
Docteur en psychologie
par
OLGA LUCIA BOSS-PRIETO

Directeur de thèse :
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Co-directeur de thèse
Ilario Rossi, Professeur associé

Jury :
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IMPRIMATUR

Le Conseil de la Faculté des sciences sociales et politiques de l'Université de Lausanne, sur proposition d'un jury formé des professeurs

- Pascal ROMAN, co-directeur de thèse, Professeur à l'Université de Lausanne
- Ilario ROSSI, co-directeur de thèse, Professeur à l'Université de Lausanne
- Marie SANTIAGO-DELEFOSSE, Professeure à l'Université de Lausanne
- Yvan LEANZA, Professeur à l'Université de Laval à Québec
- Betty GOGUIKIAN-RATCLIFF, Maître d'Enseignement et de Recherche à l'Université de Genève
- Patrick BODENMANN, Privat Docent et Maître d'Enseignement et de Recherche à l'Université de Lausanne

autorise, sans se prononcer sur les opinions de la candidate, l'impression de la thèse de Madame Olga Lucia BOSS-PRIETO, intitulée :

« The dyadic and triadic therapeutic alliance in cross-cultural health care : the case of hispanic american patients »

Lausanne, le 7 juin 2013

Le Doyen de la Faculté

Professeur
Fabien Ohl

ABSTRACT

This research project conducted in the Psychology Department of the University of Lausanne (Switzerland) evaluated the therapeutic alliance with Hispanic American Patients. From the patient's perspective, the therapeutic alliance was explored in two types of frameworks: the *dyadic* and the *triadic setting*. The *dyadic setting* is the encounter between a therapist (health professional) and a patient who ideally share the same language. The *triadic setting* is the encounter of a therapist and a patient who speak different languages, but are able to interact using the help of an interpreter. My specific interest focuses on studying the therapeutic alliance in a cross- cultural setting through a mixed methodology. As part of the quantitative phase, non- parametric tests were used to analyze 55 questionnaires of the Therapeutic Alliance for Migrants – Health Professionals' version (QALM-PS). For the qualitative phase, a thematic analysis was used to analyze 20 transcript interviews. While no differences were found concerning the strength of the therapeutic alliance between the *triadic* and *dyadic settings*, results showed that the factors that enrich the therapeutic alliance with migrant patients depend more on an emotional alliance (bond) than on a rational alliance (agreements). Indeed, the positive relationship with the interpreter, and especially with the therapist, relies considerably on human qualities and moral values, bringing the conception of humanity as an important need when meeting foreign patients in health care settings. In addition, the quality of communication, which could be attributed to the type of interpreter in the *triadic setting*, plays an important role in the establishment of a positive therapeutic relationship.

Ce projet de recherche mené au Département de psychologie de l'Université de Lausanne (Suisse) a évalué l'alliance thérapeutique avec les patients hispano-américains. Du point de vue du patient, l'alliance thérapeutique a été étudiée dans deux types de dispositifs: *le cadre dyadique et triadique*. Le *cadre dyadique* est la rencontre d'un thérapeute (professionnel de la santé) et d'un patient qui, idéalement, partagent la même langue. Le *cadre triadique* est la rencontre d'un thérapeute et d'un patient qui parlent différentes langues, mais sont capables d'interagir grâce à l'aide d'un interprète. Mon intérêt porte en particulier sur l'étude de l'alliance thérapeutique dans un cadre interculturel au travers d'une méthodologie mixte. Dans la phase quantitative, des tests non paramétriques ont été utilisés pour les analyses des 55 questionnaires de l'alliance thérapeutique pour les migrants, version - professionnels de la santé (QALM-PS). Pour la phase qualitative, une analyse thématique a été utilisée pour l'analyse des 20 entretiens transcrits. Bien qu'aucune différence n'a été constatée en ce qui concerne la force de l'alliance thérapeutique entre les *cadres dyadiques* et *triadiques*, les résultats montrent que les facteurs qui enrichissent l'alliance thérapeutique avec les patients migrants dépendent plus de l'alliance émotionnelle (lien) que sur une alliance rationnelle (accords). En effet, la relation positive avec l'interprète, et en particulier avec le thérapeute, repose en grande partie sur des qualités humaines et des valeurs morales, ce qui porte la conception de l'humanité comme un besoin important lors de la rencontre des patients étrangers dans un cadre de santé. En outre, la qualité de la communication, qui pourrait être attribuée au type d'interprète dans le *cadre triadique*, joue un rôle important dans l'établissement d'une relation thérapeutique positive.


La perfection, ce n'est pas de faire
quelque chose de grand et de beau,
mais de faire ce que l'on fait
avec grandeur et beauté.
Swami Prajñanpada

A mon père…

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FIRST CHAPTER: INTRODUCTION

Knowing that in the heart of every health professional there is a desire to relieve the mental suffering or physical pain of the person that requests health services, researchers and clinicians permanently wonder how to do better help their patients. In an effort to answer this question, an important element in the relationship between the health professional and the patient was discovered in the psychotherapeutic field: the therapeutic alliance. Many researchers identified the therapeutic alliance as the main factor that predicts psychotherapeutic success despite the type of approach or the type of treatment (Horvath & Bedi, 2002; Luborsky, 2000; Martin, Garske, & Davis, 2000). This means that a positive relationship between the therapist and the patient is essential in the development, the application, and the impact of the treatment on the patient's health, independent from the practitioner's theoretical orientation or the therapeutic setting (individual, group or family).

In a country like Switzerland, where there is a lot of socio-cultural diversity with nearly 23% of immigrants (OFS, 2011), it is necessary to be capable of working with patients of different backgrounds (Althaus, Hudelson, Domenig, Green, & Bodenmann, 2010) and to establish good therapeutic relationships with them in order to increase positive outcomes in treatment. In 2006, a group of researchers from the Appartenances Association (in which I took part) and the Psychiatry Department (CHUV) in Lausanne wondered how to better help migrant patients, who were treated in a bicultural/bilingual context. This setting also involved the presence of a third person: a *community interpreter*. This interpreter served as a translator and as a communicational and cultural bridge that facilitated the interaction between two world representations. We conducted a preliminary study to explore the therapeutic alliance in this particular bilingual/bicultural and triadic setting where the existence of a trialogue is indispensable (Boss-Prieto, de Roten, Elghezouani, Madera, & Despland, 2010). This study focused on evaluating the alliance meanings and alliance levels, according to the three participant groups (e.g., therapists, Albanese patients, and community interpreters). Results from this preliminary study show that the interpreter had an essential relational role (in addition to the cultural mediator role) that fostered the construction of the therapeutic alliance between the therapist and the patient. This means that the interpreter not only helps with the conception of a common sense in the therapy, but also facilitates the creation of a therapeutic bond.

In 2008, while enrolled in a thesis project, I decided to continue this research trend by further expanding its scope. First, I wanted to study the therapeutic alliance in a cross-cultural framework, not only in psychotherapy, but in any type of health practice. Even though the therapeutic alliance is a concept that is more frequently cited in the psychology field, its existence is inherent to any encounter between a professional and a patient that requests help. For instance, the anthropological and medical fields describe the physician-patient relationship (e.g., Good, 1994; Larson & Yao, 2005). My second interest was to compare the therapeutic alliance between *dyadic and triadic settings*. A cross-cultural health care encounter can take place in a *dyadic setting*, in the presence of a therapist and a patient who ideally share the same language. It also can take place in a *triadic setting*, in the presence of a therapist, a patient, and an interpreter.

Considering that the interpreter is an active actor in the creation of a therapeutic alliance, I wondered about the influence of the presence or absence of an interpreter in the therapeutic relationship during a cross-cultural health care encounter. What is the difference between the strength of the therapeutic alliance in a *dyadic* therapeutic frame and in a *triadic* therapeutic frame? Is it stronger with two participants who share the same language, or when a third person facilitates the communication and cultural link? Which are the factors that positively and negatively influence the therapeutic alliance in each setting, and with each participant (therapist and interpreter)?

While the therapeutic alliance has been widely researched, very few studies have been published concerning this topic in cross-cultural practice, thereby justifying the relevance of this research, especially within the health field in general. The therapeutic alliance might be a universal variable that needs to be considered as dependent on the context. Cultural values, beliefs, traditions, and life experiences shape its form and content. Furthermore, others have argued that research is needed to explore the perception of culturally and linguistically diverse patients (Bischoff, Perneger, Bovier, Loutan, & Stalder, 2003), one of the reasons for assessing the therapeutic alliance from the patient's point of view. Therefore, I wonder, what are the factors that influence the therapeutic alliance in a cross-cultural setting, according to the migrant patients themselves? More precisely, what are the perceptions of the Hispanic American community in this regard?

In order to explore all of these questions, this project's main objective is to study the therapeutic alliance between different health professionals (whom I will also refer to as therapists) and the Hispanic American patients who seek psychological/psychiatric, medical, or social services with and without the help of an interpreter in Lausanne (Switzerland). The Hispanic American population will be used as the example when evoking the migrant patients and the cross-cultural dimension. Previous contextualization questions will focus on enhancing knowledge about particularities of therapeutic settings and the Hispanic American community in Lausanne's Health System. For example, the strategies for greeting and communicating with these patients will be presented, as well as the health professional's perception of them. Lausanne's Health System is constituted of 6 institutions and 3 private practices in the region of Lausanne. They were selected due to their extensive experience in working with patients from this origin. The sample of the Hispanic American patients was chosen due to shared linguistic and cultural similarities between this researcher and this community.

The research with the Hispanic American participants was conducted using a mixed method. As part of the quantitative phase, non-parametric tests were used for the analysis of 55 questionnaires of the Therapeutic Alliance for Migrants – Health Professionals' version (QALM-PS). For the qualitative phase, a thematic analysis was used to code 20 transcript interviews in Spanish and to symbolically represent the therapeutic alliance according the Hispanic American patients' perceptions.

An opening chapter (Literature Review) will guide the reader through the meeting of the four main topics that structure this thesis, which are presented from a social macro-to-a micro perspective. The following chapter will then list the different contextualization questions that will better help me reaching this study's objective and answering the research questions. Before proceeding to the evaluation of the therapeutic alliance, the reader will get to know the methodology that guides it. Finally, the results will be presented followed by a further discussion that will consider how they can be seen in the context of the literature. A conclusion chapter will summarize and synthetize the most important elements and results of this research, highlighting the contributions of this study and its limitations.

SECOND CHAPTER: LITERATURE REVIEW

As indicated in this manuscript's introduction, this chapter will expose the reader to the four main topics entailed in this project: ***1) Cross-cultural Health Care:*** definition, characteristics, communication implications and the presence of an interpreter in therapy; ***2) Hispanic American and Latin American immigrants in Switzerland:*** migration movements between these two continents, the Hispanic and Latin immigrants, migration projects and illegal status conditions for this community; ***3) The Interpreters and the Latin American Patients in Lausanne's Health System:*** evolution of the interpretation services in the region, type of interpreters in Switzerland, representative institutions and private practices from Lausanne's health system, health issues of Latin American immigrants; and ***4) The Therapeutic Alliance***: definition, identified factors that help its existence in traditional monolingual/monocultural settings and in bilingual/bicultural ones, therapeutic alliance with the Latin American community, and therapeutic alliance when working with an interpreter.

1. Cross-cultural Health Care

To introduce the topic of cross-cultural health care, it is necessary to define a priori the terms of *culture* and *cross-cultural*. Anthropology could be described as the mother of culture. Thus, it represents the best source to provide a definition. However, given the profession of this researcher, first definitions will be located in a psychological/psychiatric domain. The concept of *culture* is described by Nathan (1986) as one self's double, which makes as aware of the human innate duplication and identification processes. *Culture* is "the human-made part of the environment" (Herkovits 1948 cited by Betancourt & Regeser Lopez, 1993, p. 630). According to Devereux (1977), the human psyche and the culture are indissoluble paired. These definitions suggest that the human being and its culture are inseparable. Every culture gives categorical references to the individual that allow him to read the world and give a sense to events (Moro, 1994). But when evoking culture, we should not only define what constitutes it, but what maintains it. In this regards, Rohner (1984) highlights an important component in

the culture definition: the transmission. He defines culture as "learned meanings maintained by a human population… and transmitted from one generation to the next" (pp. 119-120) .

Triandis, Vassiliou, Vassiliou, Tanaka, and Shanmugam (1972) describe two types of *culture*: the physical and subjective. The physical culture refers to objects such as houses, buildings, roads, etc. The subjective culture is constituted of human responses to the world such as attitudes, values, myths, spirituality, roles, etc. But, are physical and subjective cultures divisible? The ethnopsychiatry, a research domain with anthropological and clinical psychological roots, seems to involve the wholeness of the *cultural* concept. It searches to understand the human suffering taking into account the cultural contexts and the interpretations systems (Devereux, 1977), specially for migrant populations. This author had previously argued that *culture* is the key concept in understanding the psychiatry and its normal vs. abnormal barriers (Devereux, 1956).

Guided by ethnographic and empiric studies, anthropology conceives *culture* as a dynamic and evolutionary process that is built in a "plural society" by the individual's permanent quest for meaning. Its evolution depends on the personal and family trajectory (Rossi, 2003). When defining culture, Kilani (1992) puts forth as well the aspect of transmission while adding the notion of transcendence of the human thinking in the society within in a particular and universal dimension. Dasen (2002) states that among the hundreds of definitions that describe the notion of *culture*, a common base is that it enfolds symbolic meanings widely shared in a social group. Moreover, c*ulture* is strongly linked to identity, an aspect that is permanently transformed and renewed based on present experiences. Consequently, identity and culture are the basis of human meaning production (Nagel, 1994) and their built perceptions. The identity hosts the self-construction and recognition processes of the different human relationships (Gaulejac, 2009).

Looking at historic development of the concept of *culture* it is worth nothing that before it was defined as essentialist (Nathan, Devereux), meaning that there is a set of static attributes, which are necessary to its identity and function. Today, the concept of *culture* is conceived

more from a socialist perspective, meaning that it is a dynamic notion that changes and is built in the relationship with others.

The term *cross-cultural* emerges in the social sciences in the 1930s by the anthropologist George P. Murdock, who initially used this notion when referring to comparative studies based on statistical compilations of cultural data. In terms of meaning, I will define *cross-cultural* or *intercultural* as the encounter and interaction of people from different cultural backgrounds (Lüsebrink, 1998; Rossi, 2003). When searching for its signification, diverse areas appeared to be grounded on this concept: cross-cultural psychology, cross-cultural health, cross-cultural approach, cross-cultural research, cross-cultural treatment, etc. For instance, in the United States, in 1972, the Journal of Cross-Cultural Psychology was created with the purpose of providing an interdisciplinary discussion of the effect of cultural differences (Foundation, 2013) in human behavior. In Europe, the ARIC (International Foundation for Intercultural Research) was born in 1984 aiming to establish a link between French speaking researchers (ARIC) interested by the intercultural. In support of this goal, in recent years, the International Revue of Intercultural Research was created.

Other word referring to cultural exchanges is *transculturation,* term created by Fernando Ortiz, Cuban anthropologist. According to Ortiz (1940), "transculturation expresses the different phases of the transit process from one culture to the other"[1] (p. 5) that implies three phases: the acquisition of a different culture ("acculturation"), the loss or uprooting of a previous culture ("deculturation"), and the creation of new cultural phenomenon ("neoculturation"). In reference to Ortiz's work in 1970, C. Rosado (1996) defines *transculturation* as a two way process of cultural exchange between various groups which learn and impact each other without completing losing their uniqueness. In comparison to

[1] Translation of the author (TOA).

Ortiz's first definition, which seems more unidirectional, a more active role is given to the host culture.

Furthermore, the concept of *multicultural* must be evoked. Rosado's conception is defined as follows:

> "… system of beliefs and behaviors that recognizes and respects the presence of all diverse groups in an organization or society, acknowledges and values their socio-cultural differences, and encourages and enables their continued contribution within an inclusive cultural context which empowers all within the organization or society". (C. Rosado, 1996)

In Europe, there exists an antagonism of the multicultural conception because the citizen (member of a collective project) is more considered than the individual (member inseparable from his community of origin). The emergence of the notion "plural societies" goes beside with the idea of a citizen who evolves along with migration movements. The French literature relates the term *cross-cultural* to the question of diversity and similarity in a continuous transformation social process that takes place in a "cultural plurality" (Rossi, 2003) rather than in a "multicultural context". *Cross-cultural* is not just the fact of being face to face with a person from a different cultural background. It connotes as well a dynamic construction of exchanges (Leanza & Klein, 2002) in the presence of cultural diversity. When considering the current definition of *culture* as a dynamic and interactional process, for the migrants the transculturation process is built through their migratory journey and defined by a socio-politic inclusion. In this sense, the practitioners become cultural agents who help migrants construct their new identity.

Based on these cultural approaches and guided by the objective of this study that aims to explore the therapeutic alliance in Lausanne's health system, I will apply the *cross-cultural* concept in a health care setting. I will define *cross-cultural health care* as the medical encounter and interaction between health providers and migrant patients who request health services to help them address their physical, psychological or social issues.

A *cross-cultural health care* encounter implies the meeting of two socio-cultural systems (Jahoda, 2012). The socio-cultural systems are constituted of languages, parenting systems, and ways of doing (Moro, 1994). Language is the main vehicle in the transmission of cultural perceptions, values, beliefs, behaviors, and representations. In *cross-cultural health care*, interactions are very difficult without the help of a common language. A relationship could be hardly built between the therapist and patient with out common communication means. The patient's language and cultural representations are the core of the therapeutic relationship (Moro, de La Noë, & Mouchenik, 2004). For this reason, the next chapter focuses on communication in cross-cultural health care before moving to the description of the Hispanic American community and Lausanne's health system.

1.1. Communication in Cross-Cultural Health Care

Cross-cultural communication is the result of the encounter and interaction of people from different cultures (Lüsebrink, 1998) and is the product of migration and globalization processes (Piller, 2011). It implies the awareness in all participants of their particular linguistic and culturally diverse origins. Effective communication in cross-cultural health implies the presence of an interpreter when no common language exists between the therapist and the patient. This presence of an interpreter infers a trialogue between participants. A trialogue is a communicative exchange occurring within a triad (Kerbrat-Orecchioni & Plantin, 1995). A trialogue does not request the simultaneous verbal expression of three participants, but a series of harmonic dialogical interactions that allow the triadic communication in a common language through the alternation of speech turns. The trialogue does not have a fixed structure in the course of conversational exchanges. This means that there could be changes regarding the interlocutor's status and their roles mobility (Malheiros-Poulet, 1995). The dynamics of communication and dialogue/trialogue must be different in somatic than in psychological encounters. While this study considers both domains, it should be said that they are not equivalent knowing that language is the base of human interaction in psychological settings.

The lack of a common language between the therapist and the patient appears as a negative incidence over the patient's capacity to share his health problems (Renteria, 2003) and provokes certain dependency of the patient towards the relatives or close ones who translate. Indeed, "there is a strong evidence that the whole healthcare process is at risk when these barriers are not overcome" (Leanza, 2005, p. 167). Referring to language barriers in psychiatric care, a systematic review of the literature from 1973 until 2009 reveals the existence of "multiple potential sources of miscommunication and distortion due to gaps in communication, particularly when no interpreters or ad hoc interpreters are present" (Bauer & Alegría, 2010, p. 770).

An extensive body of research has demonstrated "that problems of communication and interpretation become exacerbated between a therapist and a patient of dissimilar socioeconomic and cultural origin" (J. W. Rosado & Elias, 1993, p. 452). This means that not only the language represents a barrier in cross-cultural practice. According to these authors, diverse ecological (environmental) and psychocultural factors (e.g., different education levels, legal or sociocultural status) could play an important role in communication, meanings representation, and thereby in the treatment development.

The verbal expression of the patient in his mother tongue during the therapy is a precious resource because it allows the individual's natural connection with his whole being in a spiritual, physical and psychological dimension. In the same manner, the language choice is "the major factor in the linguistic construction of cultural identity" (Piller, 2000, p. 17). Considering the effects of bilinguism, it was found that Spanish-English bilinguals are capable of expressing more affect while speaking in their Spanish mother tongue (Guttfreund, 1990). This author concluded that for the Hispanic population the therapeutic process in Spanish might be far more meaningful due to the comfort felt when expressing themselves in their mother tongue. Furthermore, it was showed that assessments performed in the migrant's non-primary language lead to incomplete or distorted results, whereas evaluations conducted with non professional interpreters my contain interpretation errors (Baker, Hayes, & Puebla Fortier, 1998).

Based on these ideas, could we state that sessions performed in the patient's mother tongue and with a health professional from the same background facilitate the treatment and probably the therapeutic alliance? If the answer was positive, in a country like Switzerland with such a high percentage and diversity of immigrant residents, how could we always guarantee the patient to be treated on his native language and by a therapist of the same background? Within these culturally diverse circumstances, other possibilities should be considered to reach the closest ideal conditions of therapy. In this case, an interpreter might seem the best option to serve as a language and cultural bridge.

1.1. The Interpreter

> "We don't know the exact date by which language as such was first invented, but it is safe to assume that shortly after signs and gestures no longer sufficed for decent communication the first interpreters came along to facilitate understanding between the speakers of already different tongues. It is from Ancient Egypt that the oldest references to interpreters have survived" (GmbH, 2013, p. 1).

The resurgence of a more contemporary interpreter figure has come along with the increasing globalization and migration processes. Countries with large immigration processes have become sensitive to the increasing cultural and linguistic diversity and in consequence, to the need of interpreters to facilitate the communication with professionals. But, how do we define an Interpreter in today's society?

The interpreter is the facilitator of the co-construction of a dialogue and a reality (Rossi, 1999) between two different actors than do not communicate through a common language. He[2] renders the meaning of words and cultural codes in a form of speech that is adapted to the level of understanding (Faucherre, Weber, Singy, Guex, & Stiefel, 2010) of the therapist and the patient. The "linguistic intermediate", as Malheiros-Poulet (1995) calls it, has the

[2]In this research the personal pronoun "he" is used indifferently for masculine or feminine.

responsibility of being clear and coherent while keeping (as closest as possible) the interlocutor's style and intention.

In the mental health field, interpreting entails an ongoing relationship where highly charged material is involved (K. Miller, Martell, Pazdireck, Caruth, & Lopez, 2005). For this reason, the interpreters play a *cultural* and *relational* mediation role in addition to the language translation (Boss-Prieto et al., 2010). In the cultural side, the interpreter participates in the construction of the intercultural through the explanation of socio-cultural values and norms implicit in language on both sides (Goguikian Ratcliff & Changkakoti, 2004). In the relational side, the interpreter serves as the center of the co-construction of meanings and interactions that facilitate the creation of a relationship (Boss-Prieto et al., 2010). The mediation role of the interpreter becomes essential in the establishment of the alliance in the triad, guided by his central position which searches stability and equilibrium between the participants (Elghezouani, de Roten, Madera, & Boss-Prieto, 2007). These elements will facilitate the creation of a bond and mutual cooperation.

From a relational point of view, the interpreter becomes a significant person for the patient due to motives that transcend the interpreting job during the clinical session (K. Miller et al., 2005). Interpreters are the first point of contact in this human encounter; they are receivers that transmit a significant emotional content. At the same time, they represent the first resource in case of crisis and/or in between the sessions. According to Tribe (1999), the bicultural workers (interpreters) should be more concerned with "the *feel* of the words and emotional content" (p.570) in the psychological domain than in the physical medicine, therefore the literal translation adequacy would be applicable only in certain spheres.

In therapeutic sessions with immigrants/refugees the interpreter's job is more active because his verbal and non-verbal communication, including translation, indirectly contains a therapeutic and healing function (Elghezouani, 2004). In addition, interpreters play a major role in helping refugees link up to relevant local networks and to access mental health services as this population often searches help only when they show physical symptoms (Tribe & Morrissey, 2003). Hsieh, Pitaloka, and Johnson (2012) findings suggest that "medical

interpreting in mental health care settings may require a specialty-specific communicative style that is different from all other clinical contexts and accommodates the delicate balance of provider-interpreter-patient relationship" (p. 8).

Whereas the interpreter's job involves word translation, his role focuses on helping the construction of meanings between two linguistic worlds guided by the goal of conflict resolution (Leanza, 2006). The interpreter becomes acquainted with two cultures thanks to, on the one hand, his own immigration experience (in most part from the patient's country or continent of origin) and on the other, thanks to his adaptation and integration to his adoptive country. According to Leanza (2006), the interpreter plays also a role of a "cultural agent" when intervening as an explicator, defender, and negotiator of the cultural differences. In Switzerland, an interpreter with the characteristics previously described is known as a *community interpreter* who makes part of the category of professional interpreters according to INTERPRET, Swiss Association for Community Interpreting and Cultural Mediation (Interprèt, 2011a). It is important to highlight that *community interpreter* will be the term equally used during this research study when referring to professional or trained interpreters.

1.2. Type of Interpreters

The interpreter's role is determined by the therapist's theoretical perspective and by the institution's approach (Singy & Guex, 2005). While some orientations may request a minimal interference of the interpreter in the therapeutic encounter, others may ask for his active participation. Its role depends on the power that is given to him (Leanza, 2008). Some health professionals consider the interpreter only as a language helper, others as an active participant, or even as a colleague. The interpreter's role could also be defined by the therapist's expectations. A study in bilingual health communication shows that provider's expectations largely differ according to their work domain. Nurses seems to place more importance on the interpreter's ability "to assist patients outside of the medical encounter and to advocate for the patient" (Hsieh et al., 2012, p. 1).

The interpreter's role varies from one context to the other (Leanza, 2005) and expands or contracts according to the characteristics and skills of the interpreter and the health provider (Beltran Avery, 2001). For instance, Raval and Maltby (2005) believe that by involving the interpreter as a co-worker or colleague, his personal and cultural contributions are more constructive for the therapeutic setting. According to Bot 2005 (cited by Leanza, 2010a), there exists two type of interpreters in psychotherapy interventions: the translation-machine and the interactive-translator. The first interpreter model must keep a neutral position where emotions are not involved and a physical distance should be kept between him and the patient. We might think of a robot. Opposite to Raval's conception, the interpreter has no saying in the direction of the session. The second interpreter model, which sounds more human, considers the interpreter as a full person whose contributions influence the triadic relationship. Bots calls this second model a "three person psychology".

The interpreter's role is as well determined by the interpreter's type. There exist professionals vs. non-professionals interpreters who facilitate the bilingual communication. Table 1 illustrates this grouping based on an international (Hsieh, 2006) and local classification (Interprèt, 2011a).

In the bilingual health communication, Hsieh (2006) classifies the interpreters into 5 different types: chance interpreter, untrained interpreter, bilingual health provider, on-site interpreter and telephone interpreter. For the purpose of this study, Hsieh's classification is central in contextualizing the cross-cultural health encounter. For this reason, more in depth definitions are presented.

Table 1. Type of Interpreters who facilitate the bilingual communication

Professional Interpreters (Classification according to INTERPRET Association 2011, and Hsieh 2006)	Non-professional interpreters (Classification according to Hsieh 2006)
1. **Translators:** langue specialists who translate written texts. 2. **Interpreters:** langue specialists who master a foreign language orally. 3. **Community interpreters:** specialists of interpretation, in a trialogue situation, with people of different linguistic origin. Hsieh calls them ***on-site interpreters*** and talks about the importance of mastering a medical language as well. 4. **Mediators:** intermediaries to facilitate conflict resolution. 5. **Telephone interpreters**: trained people who facilitate the communication between the health provider and the patient through local phone services.	1. **Chance Interpreters:** close friends or relatives who translate for the patient. 2. **Untrained Interpreters:** employees from the same health institution who have a different job activity than interpreter, but occasionally translate. 3. **Bilingual Health Providers**: health professionals who speak the patient's language as their second language.

1.2.1 The Chance Interpreter

The *chance interpreter* (e.g., a family member or friend) is someone who has a close rapport with the patient and plays a dual relationship while translating (e.g., child-interpreter).

While there's a previous alliance between the patient with his translator, it is not a therapeutic one, therefore inappropriate to the problematic and characteristics of the encounter. For instance in the example of child-interpreter, the child can be exposed to the parent's private life which could prevent therapeutic work to be done or cause more difficulties in the family's dynamics. Moreover, there is a risk of parentification (inversion of roles between parents and children) and a risk of damaging the parental image by reversed roles (Métraux, Weber, Singy, & Guex, 2003). In cases in which the infant plays a dual role of expert and patient, this paradoxical position puts at risk the psychological health of the child. Like the example of a school setting in which the student with learning/behavioral difficulties translates between his parents and his teacher (Ronsenbaum, 2003).

When a friend or a close one plays the role of an interpreter in a health encounter, the patient becomes dependent on this last one for the development of the session and the choice of the information content to be transmitted. This dependence can end up in ignoring the patient's presence because the *chance interpreter*, due to his pre-existing relationship with the patient, often takes the power of what must be disclosed and how it should be communicated. The pre-existent emotional bond with the patient might lead the *chance interpreter* to a subjective position and to subjectivity in his contributions while possibly contaminating the direction of the treatment. Research has shown that family interpreters act as a third participant who often speaks for himself rather than transmitting the words of the doctor and the patient (Rosenberg, Seller, & Leanza, 2007). The ad hoc interpreter (as Garcés calls the *chance interpreter*) acts more as an advocate than only as interpreter. He also frequently takes over "the doctor's role of questioning and counseling the patient or providing information about the patient directly to the doctor" (Valero Garcés, 2005, p. 207). According to this last author's study, the *chance interpreter* often adds or omits information and/or repeats and invents new words.

Leanza, Boivin, and Rosenberg (2010) found as well that interpreters who have a family relationship with the patient often behave as the main interlocutors, to the extent of excluding the patient from the session. According to their study, the interpreter family member has the

tendency to impose its agenda and to monitor the progress of the session. Family physicians reported difficulties in gathering precise and complete information from family interpreters (Rosenberg, Leanza, & Seller, 2007). Communication problems and misunderstandings are obviously more existent because the patient will ignore parts of what happens in the session and will not be sure that everything will be translated in both directions. Confidentiality is less guaranteed for the patient (Faucherre et al., 2010). The content of the session can be easily transmitted to other relatives or to the community because the responsibility of the professional secrecy is not inherent to the *chance interpreter*.

1.2.2 The Untrained Interpreter

The *untrained interpreter* is a professional or employee from the same institution who has another job activity than interpreter. When he takes a translation task, a confusion of roles is created for all participants in the session. Regarding the patient, he will not know if this person is his interpreter or the receptionist of the institution for example, or the cleaning lady. What is the role of this kind person who came to help us communicate? What is its involvement in my treatment? The patient would certainly hesitate between going towards the *untrained interpreter* to take an appointment or to clarify some information of his session. Or both? The patient may be forced to ask the *untrained interpreter* to play an inadequate function for that exact moment. For example, the fact of requesting the *untrained interpreter* for treatment issues while he is executing its real function. Such interpreters can also find themselves having work team difficulties if other colleagues must assume their jobs while they translate (OFSP, 2011). In addition, the double role will not attribute any recognition to the employee for his supplementary task, and the absence of its real work position will have an impact on its productivity.

While many researchers have proven the inadequacy of *the chance and untrained interpreter,* the implication of closed members and non qualified staff in a translation role continues to be a fact (Fleischer, 2002). In the case of Spanish speaking patients in California (USA), a study revealed that bilingual untrained nurses-interpreters often translate in cross-cultural health care practice. Unfortunately, interpretation errors were found that frequently

end in misunderstandings, omissions and interpersonal conflict (Elderkin-Thompson, Cohen Silver, & Waitzkin, 2001). Additionally, the confidentiality could not be assured because the improvised interpreter is not submitted to the professional secret (Faucherre et al., 2010).

In a large study recently completed in a Swiss Hospital (Hudelson & Vilpert, 2009) where doctors, nurses and social workers constituted the main participants, findings show that 66% of therapists prefer working with ad hoc interpreters (*chance and untrained interpreters*) because they are easier to organize and immediately available. Half of these participants have even served themselves as interpreters. Existent financial pressures also influence these health professionals' practices. The authors of this research believe that there is an important need to create "an institution-wide-culture" and "a hospital policy" that could influence the practitioner's culture regarding the use of professional interpreters. For example, in Montreal (Canada) the majority of health institutions organize their budgets to afford trained interpreters: "It is a matter of education" (Hemlin, 2011), awareness, and conviction. In Switzerland, the need of raising the professional's consciousness about the limitations of using the patient's relatives in the translation and about the benefits of using trained interpreters was identified over a decade ago (Bischoff, Tonnere, Eytan, Bernstein, & Loutan, 1999).

This type of interpreter, who intervenes occasionally and must keep an emotional distance from the patient, could weaken the construction of a therapeutic alliance due to the lack of collaborative and emotional bonds.

1.2.3 The Bilingual Health Provider

Continuing with Hsieh's classification, the *bilingual health provider* is a health care professional who speaks the patient's native language as his second language. While reducing the need of an interpreter can facilitate a better rapport with the physician (Baker et al., cited by Hsieh, 2006), the lack of deep knowledge related to the patient's culture and values can produce discrepancies in their perceptions. Even though Hsieh considers this person an interpreter, I will not include it as a type of interpreter because, from my point of view, it does not imply the presence of a third in the session.

1.2.4 The On-site Interpreter (Community Interpreter)

In terms of this research the *on-site interpreter* represents the *community interpreter* who is a specifically trained professional in health care settings. In a trialogue situation, he manages a medical language in addition to his bicultural knowledge. The *community interpreter* is an actor, a facilitator of the co-creation of a dialogue and the construction of a world reality when a common language does not exist (Rossi, 1999) in a health encounter. With the explanation of values and socio-cultural norms implicit in the language of the therapist and the patient (Goguikian Ratcliff & Changkakoti, 2004), the *community interpreter* can be actively involved in the patient's treatment through the sharing of representations concerning diseases and health beliefs. "In a favorable context, the interpreter's interventions are not only essential, but are also susceptible to facilitating conditions for real intercultural care, and even to incite innovative ways of managing cultural differences…" (Leanza, 2008, p. 218).

As a result, the cultural knowledge of each one (therapist/patient) will contribute to the contextualization of the patient's illness and in consequence to its treatment. The *community interpreter* fosters a certain form of transition between what the patient says and what is said from his words in a second language (Elghezouani, 2010). Considering that the therapeutic alliance is the main factor when predicting good outcome in therapy (Horvath & Bedi, 2002; Luborsky, 2000; Martin et al., 2000), the possibility to create an alliance in a triad would increase the collaborative and emotional bonds towards the patient's recovery and for the benefit of his well-being.

Indeed, the assistance of a *community interpreter* facilitates the establishment of anamnesis, diagnoses, and treatments clearly understandable to the language and culture of the patient (Es-Safi, 2000). This in long-term, can reduce the number of sessions and costs involved. While interpreting services increase the initial health care expenses, its use prevents the escalation of long-term costs through a lower number of visits (Bischoff & Denhaerynck, 2010).

Moreover, findings from a research study conducted in Lausanne reveal that the presence of a *community interpreter* reduces somehow the obstacles inherent to the encounter between a doctor and a migrant patient (Singy & Weber, 2001). The professional interpreter transmits the patient's reluctance unlike family interpreters (Leanza, 2010b), facilitating the identification of factors that demote the therapeutic alliance with particular patients. The interpreter's "cultural and linguistic expertise" could be a treasured resource for the health professionals in understanding the patient's distress (Hsieh & Jung Hong, 2010).

1.2.5 The Telephone Interpreter

Hsieh's last classification refers to the *telephone interpreter* who is a trained person available through local phone services that often provide special machines with two megaphones. This allows the patient and the health provider to have an indirect communication through a third invisible person. In this case, there's a major obstacle of the loss of non-verbal interaction and emotional content. Having a *telephone interpreter* instead of a *on-site interpreter* is inadequate in cases where emotional support is needed as an essential care intervention (Hsieh & Jung Hong, 2010). Therefore, the *telephone interpreter* is inadequate for the psychological domain and useful for precise or urgent medical interventions. Since 2011, a national interpretation service of this type exists in Switzerland (Interprèt, 2011b) as a possible solution when language barriers interfere with communication.

1.3. Limitations and obstacles when using and interpreter

Misunderstanding is cited as one of the principal limitations of the presence of an interpreter. During the translation process, a number of misunderstandings could influence its sense due to an inadequate vocabulary from one language to the other or due to an insufficient knowledge of the translator (Junod, Papeta, Ballereau, & Moutet, 1991) regarding cultural meanings, which sometimes are implicit in the expressions. Another limitation is time. It is clear that a dialogue will require less time than a trialogue where there are two different languages. "The use of a translator, when necessary, doubles the time of the anamnesis in

comparison to a direct dialogue" (Graz, Vader, & Raynault, 2002 p.80). For certain patients who share the same language with the interpreter, but belong to a different ethnicity, the presence of the interpreter could be perceived more as threat.

Other difficulties that have been brought up when working with an interpreter is the therapist' feeling of being excluded from the interaction and of not having a privileged relationship with the patient (Goguikian Ratcliff, 2010), and the risk of malpractice litigation (Hsieh & Jung Hong, 2010). These last authors describe malpractice litigation as the patient's uncertainty "about whether the specific information comes from the provider or the interpreter" (p. 196). This based on the fact that interpreters may speak for the health professionals or for themselves, sometimes without making the distinction of whom is the main interlocutor.

According to Fleischer (2002), other obstacles in using an interpreter for some doctors in private practice in Switzerland are: a) the absence of a list of interpreters available, b) the confidentiality issues and c) the time required to create an interpreting system. Some other obstacles in accessing an interpreter are justifying his/her presence and assuming the expenses. In Switzerland, "the right to access health services by the allophone patients is linked to the right for them to benefit from the presence of an interpreter during a medical appointment"[3] (Ayer, 2004, p. 56). Furthermore, the Constitution's article related to the informed consent indirectly evokes the right to an interpreter for allophone patients: "the patient needs to be duly informed, in a clear, precise and comprehensive manner about the nature of the diagnostic, the treatment and its risks"[4] (Ayer & Gilbert, 2004, p. 5).

While this is covered in the Constitution, there is no specific/explicit norm that regulates the professional interpreters' activity. Consequently, it becomes a problem when deciding who

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would assume its costs: the insurance company, the government, the patient, or the practitioner? Ayer & Gilbert (2004) argue that the presence of an interpreter is a condition of the essential health rights that has to be guaranteed by the government as a obligatory service, and by the insurance companies in private practice as a auxiliary service to the doctor. However, in the reality this seems to be ignored. One decade ago, the Swiss health insurance companies did not foresee the eventual payment of translation fees (Métraux et al., 2003). Nevertheless, today two motions have already been filed in Switzerland at the federal level requesting to include interpreters among service providers recognized by the health insurance (Faucherre et al., 2010). In the meantime, official interpretation organizations recognized by the Federal Migration Office received some funding from the country's confederation or from different administrative divisions (Appartenances, 2010).

1.4. Training of Interpreters

As previously seen, the *on-site interpreter* (Hsieh, 2006) or *community interpreter* is the more appropriate type of interpreter for a cross-cultural setting due to his professional competence. While their bicultural knowledge is an inherent strength that has come with life experience, additional training is necessary to adapt this skill to their work field. According to Métraux & Alvir (1995), the interpreter has to benefit from a specific training in order to assume his role and activities. This training should include the following subjects: "migration process and its psychosocial impact, therapeutics projects, interpreter's role, translation techniques in the psychosocial domain, ethic in the interpreters' work, and interpreter's role in health prevention and promotion" [5](Métraux & Alvir, 1995 p.25-26). These authors add that a professional collaboration is important, in particular through a common supervision. But training is not the only requirement to form competent interpreters. Leanza, Ogay, Perregaux, and Dasen (2001) consider that personal qualities such as empathy, sensibility, openness, trust,

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respect, modesty, curiosity and non-judgmental attitude are conditions to become an interpreter.

In order to fulfill these needs, Appartenances Association (Association Appartenances, 2012) has a unit specialized in training and offering services of *community interpreters* in Lausanne's region and other surrounding areas. For example, Appartenances offers a Suisse community interpreter certificate and/or federal license through two modules that imply 175 hours of training and 102 hours of personal work. These courses focused on: 1) interpretation techniques and the interpreter's roles in trialogue situations, 2) identification of the person's own references and sociocultural resources, personal work on his own migration experience, 3) discussion of different migration and intercultural approaches, 4) acquisition of political and legal knowledge regarding migration, 5) information and contact with different health, social and educational institutions in the region, 6) exploration of research information techniques concerning different Suisse structures and structures in the native country, and 7) learning of specific terminology in different health domains. This training should be accompanied of individual supervision in the work field. From their perspective, the future interpreter's reference to their personal migration experiences becomes a main indicator of their future performance (Association Appartenances, 2012), as does the value given to their culture of origin (Métraux, 2002). The knowledge of the local institutions in the medical network is essential (Métraux, 2002), because their role implies, at times, the support and company of a patient(s) through different health structures.

Based on empirical findings of the implication of interpreters in pediatric services, Leanza (2005) suggests that future interpreters should explore, during their training, 4 potential roles which are implicit to their work: 1) a system agent who transmits norms and values from the society to the patient; 2) a community agent who presents the migrant's norms and values as potentially equally valid; 3) an integration agent whose interventions go towards helping the migrant patient find an "in-between" behavior in their everyday life; 4) a linguistic agent that, with his maximum possible impartial position, finds a proper translation.

Results from the study conducted in Switzerland in 2002, indicate that, on the one hand, doctors in private practice frequently find communication difficulties with their migrant patients, and express their need to have access to trained interpreters. On the other hand, they demonstrate that these same practitioners need themselves a training focused on the triadic therapeutic work (Fleischer, 2002). Working in the cross-cultural field requires skills beyond the ability to speak two languages fluently. For this reason, training is necessary for both interpreters and therapists (Tribe & Morrissey, 2003).

1.5. Training of Health Professionals

Due to "the internationalization of illnesses and the cultural pluralism that characterizes more and more today's society"[6] (Rossi, 1999 p.228), the health professionals should also be guided in the work performed in cross-cultural health care. According to Rossi (1999), in the health care and migration domain, the training should be focused at least on the following main objectives: creation of intercultural awareness related to exchanges and communication in the therapist/patient relationship; insight around cultural representations of illness and its treatment; link between socio-cultural health issues and migration processes; and types of work and collaboration with interpreters when needed. These themes evoke the therapist's need of exploring the therapeutic alliance with his patient from a diverse origin and with his interpreter in triadic settings.

According to Bodenmann, Madrid, Vannotti, Rossi, & Ruiz (2007), the training of health professionals should also include the development of *Cross-Cultural Competencies (CCC)* such as the following: 1) awareness of what it means to talk about an specific population 2) some knowledge of the geographic, cultural and religious context of the patient's country of origin 3) development of an open attitude towards the patient's personal and spiritual beliefs

[6] TOA.

4) awareness of the existence of different types of health systems and models to explain illness 5) efficacy in the communication, especially in trialogue when the presence of an interpreter is needed and 6) insight regarding the professional and personal reasons that motivate the work with immigrants and/or with a specific community.

Leanza (1998) states that the training in the intercultural field should drive the professionals to transform cultural stereotypes into a consciousness of the diversity that exists regarding the meanings given to health, illness, and health care. He believes that this movement is facilitated by a training based on health anthropology, which I think, means a training that stands on the analysis of the influence of the context, time, and place on the human's health concept. Results from a study in Switzerland reveal that, according to migrant patients themselves, the quality of communication in the session can be improved with specific training given to their primary care physicians (Bischoff et al., 2003). This training gives the health professionals some knowledge about the therapeutic encounter with migrant patients and focuses on working with interpreters in a triadic setting.

While the ideal is to use *community interpreters* in cross-cultural health care practice, the reality shows that health professionals work more with non-professional interpreters than with trained interpreters. For this reason, guidelines should include training therapists to work with both types of interpreters, showing similarities and differences and adapting the encounter to each case (Brisset, Leanza, & Laforest, 2013; Rosenberg, Leanza, et al., 2007).

2. Hispanic American Community

A *community* refers to a group of people who share characteristics or identities. When it refers to a community leaving abroad, *diaspora* seems to be a term often used. While *emigrant communities* entail a place of origin gone forever, d*iaspora* reveals the links between the motherland and the host land (Fibbi & Meyer, 2002).

However, in this study, I will retain the term *community* instead of *diaspora*, because this last one appears to often refer to an intellectual migration movement of "brain drain" or "brain gain" through highly skilled expatriates (Meyer & Wattiaux, 2006), which does not exactly corresponds to the characteristics of the majority of Hispanic American immigrants in Switzerland, and participants of this study.

I will define the Hispanic American community or population as a group of people who share geographic origins (South and Central America) and have linguistic similarities (Spanish). This while acknowledging that different ethnics, races, social groups, social levels can constitute a community (Betancourt & Regeser Lopez, 1993) and make an internal heterogeneity (Wagley & Harris, 1955).

2.1 Hispanic American and Latin American Immigrants in the World

In 1957, Murdock attempted to classify selected cultures into categories according to certain ethnographic standards. Within this classification, the Hispanic American belonged to the classification called "South America", which included the Antilles, Central America, and Yucatan (Murdock, 1957). Today, more ethno linguistic considerations are taken when determining cultural boundaries. The Hispanic American community refers to people who are originally from a country of South America or Central America and whose mother tongue is Spanish. In consequence, Brazil (mother tongue Portuguese), Guyana (mother tongue English), French Guiana (mother tongue French) and Suriname (mother tongue Dutch) are the countries located in this continental region that do not make part of this classification.

When we refer to Hispanic Americans plus Brazilians, we speak about Latin Americans. Overall, when statistical and socio-demographical information is provided by different sources, it is more common to find the nomination Latin Americans, where Brazil is included, due to their cultural proximity. For this reason, during the following subchapters, I will refer to Latin Americans overall, while I remind the readers that my study is concerned only with Hispanic American patients.

Latin Americans represent 15% of all international migrants in the world (OIM, 2010a). In 2009, they made part of the 62 million of migrations South-North and of the 61 million migrations South-South (Wihtol de Wenden, 2010). The Latin American immigrants, in most cases, leave their country of origin searching for means to improve their economical situation in foreign countries, especially in Western Europe and North America. Many of them who have been denied visas found all types of resources to reach the targeted country against the law, subsequently finding the status of illegal immigrants[7]. In a few cases, they appeal to professional frontier runners. But in most cases, the Latin Americans find resources to emigrate with the help of the family and community already installed in the foreign country. The compatriots' solidarity helps the illegal immigrants cross the oceans and take the first steps in foreign lands. Sometimes they even afford the trip expenses. Furthermore, they guide them in their adaptation process to the host country by transmitting information regarding communicational codes, behavioral meanings, and life strategies.

According to Palomino (2004), since 2001, after the terrorist attacks, tougher immigration policies in the United States diverted Latin Americans from the American dream to an European land of opportunity, rapidly increasing the number of illegal immigrants in Europe the following years. Nevertheless, Europe has "unwillingly and painfully become a land of immigration" (Wihtol de Wenden, 2007, p. 55), while it struggles to include non-Europeans in their identity. According to this last author, this rejection is manifested by tense border controls and forced expulsions.

In general and in a simple manner, there exist two main categories of Hispanic American immigrants in the world: the legal and the illegal. Through the following subchapters, the reader will discover the type of residents that live in the Swiss territory.

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[7] In this study, I will use the terms illegal and undocumented in equal manner when referring to immigrants with no legal status.

2.2 Latin American Immigrants in Switzerland

According to Bolzman, Carbajal & Mainardi (2007), the first migratory movements between the Latin Americans and the Swiss took place in XIX century. Surprisingly for today's reality, these movements were in the opposite direction: several Swiss emigrated towards the whole American continent to escape from poverty and to find better life conditions. We do not know exactly when this migratory movement changed its direction. However, according to these last authors, since 1970, the Latin American population in Switzerland has significantly risen. It was also during this year, that the first exiled from the Argentinean and Chilean' military dictatorship arrived in Switzerland. This community was mainly composed of economic, political, or artistic elites seeking for temporary residence (Bolzman et al., 2007). Unlike them, today's Latin American community residing in Switzerland is characterized by being mostly undocumented, and in consequence "the non-wanted and intruders", as these last authors state.

The Latin American emigration to North America and Europe experienced a large growth in the first decade of the XXI century. The inadequacies of labor markets in Latin American countries and the emerging support of migration networks solidified and intensified the migratory movements from the south (Gomez, 2005). Overall, we estimate that there exist two types of migratory groups in Europe. The first one is of *sedentary* nature. Once installed, it remains several years in the host country with or without residence permit. The second one is of *nomad* nature. It moves constantly shifting from one country to another in the same continent, with the purpose of discovering new possibilities and avoiding being caught in the illegality. This study provides an overview of the first group: *sedentary* nature.

Nowadays, according to the report of the Federal Swiss Office of Statistics (OFS, 2010), the Latin American countries more represented in Switzerland are: Brazil (18,476 residents), Colombia (4,316 residents), Chile (3,759 residents) Peru (3,129 residents), Mexico (2,925 residents), and Ecuador (2,481 residents). Looking at each country's specificities, the amount of Brazilians immigrating in Switzerland constantly increased between 1995-2010. The immigration coming from Colombia slightly decreased in 2007, otherwise it constantly

increased during this period. The immigration coming from Ecuador constantly increased, and the immigration coming from Peru slightly decreased since 2006. Concerning Mexico, it slightly decreased in 1998, otherwise, it constantly grew. Furthermore, Chile experienced two constant decreasing periods (1995-2000 and 2002-2008) in the last 15 years. The end of the Chilean dictatorship in 1990 could possibly explain these changes, especially of the first period.

This information refers to the database of legal immigrants in the country. However, according to (Valli, 2003), Latin American immigrants in Swiss territory are mostly illegal. Health professionals in Lausanne corroborated this information (Sangra Bron, 2006). Therefore, statistics of the OFS are greatly away from reality. The irregular migration is explained by the imbalance between supply and demand (OIM, 2010a) in Latin American countries, and because of the strict immigration laws in the host countries. For instance, in the last decade, Latin Americans have had no socio-economic-political recognized reasons to request asylum in foreign countries, so the most part find the illegality as the entrance door. According to Bodenmann & al. (2003), between 2000-2003, the population of illegal immigrants in Lausanne rapidly increased to about 30%.

However, the massive migration of Latin Americans in Switzerland decreased in recent years (Valli, 2007) most likely due to the hardening of the Swiss immigration laws and recently due to the solidification of the law against illegal work (new federal law of January the 1st of 2008 against the moonlighting). Other families might have been deported or they returned to their countries thanks to the « assisted return » (law of 2007), which allows families to have some financial support to go back to their countries of origin without being denounced to the police when having no legal status. Moreover, the world economic crisis of 2009 decreased the employment in Switzerland as well. According to the testimony of some participants interviewed for this project, many Latin American immigrants have left for Spain to legalize their status. Others take this country as the gateway to Europe, and once inside, they move to other countries of this continent. The International Organization for Migration states that Latin American emigration to Europe is directed predominantly towards Spain,

representing 38% of the immigrants in this country (OIM, 2010a), which is expected due to language similarities.

2.3 The Undocumented Latin American Immigrants

Recent sources estimate that 70% of illegal residents living in Lausanne are Latino (Bodenmann, Althaus, Carbajal, Marguerat, & Kohler, 2010), which corresponds to approximately 4,200 of undocumented Latin Americans only in the region of Lausanne (which has 135,000 inhabitants).

It is believed that the majority of the illegal Latin American community in Lausanne, and in the whole Swiss territory, is originally from Ecuador. When looking at the OFS statistical report, we could see that in 2007 only two thousand Ecuadorians were legally registered in Switzerland. However, "we think that approximately 15,000 might live in Swiss territory" (Montaluisa Vivas, 2007, p. 108).

Why so many Ecuadorians left their country even though there is no war, dictatorship or, political declared conflict? In 1999, a national bankruptcy created the installation of the dollar system and a massive unemployment in the country. The new country's face was characterized by major insecurity, corruption, and lack of faith in its government. In 2000, the number of people touched by poverty went up to 71%, and those touched by the extreme poverty up to 31%. In consequence, migration became a survival instrument (Montaluisa Vivas, 2007).

Another important characteristic concerning the illegal community in Switzerland is that it is mainly constituted of women, either accompanied by their children, or with children back home (Valli, 2003, 2007). The most frequent case is the mother who migrates to work abroad while leaving her children at their home country, under the care of aunts or grandparents during several years, as it happens in the United States (La Roche, 2002). These women's perception about their irregular status is often normalized by their belief: "We know that we are in a place where we are not supposed to be…but we do not do anything bad… anything

illegal"[8] (Carbajal, 2001, p. 12). They live "legally in the illegality" driven by their goal of improving their families' life conditions and especially those related to their children.

When there are no children in the home, their priority goes towards helping other family members such as parents, brothers or sisters, etc. These women often work in domestic or childcare jobs and are in their thirties (Bodenmann et al., 2003; Carbajal, 2004; Valli, 2003). They often speak a very rudimentary French that sometimes prevents them from answering simple questions (Sangra Bron, 2006). According to this last author, this language barrier "generates a form of disability that could result in the patient's loss of self-esteem" and become "a supplementary obstacle in encountering resource people"[9] (Sangra Bron, 2006, p. 42).

Today, women immigrate not following their husbands, but by themselves, or as the first family member who arrives in the foreign country. On the one hand, this happens due to their new trend searching for independence from men, and on the other hand, due to an illegal employment market that offers better possibilities in activities performed by women. Nonetheless, as Wolff & al., (2005) state, these undocumented women have difficult living conditions, characterized by permanent fear of being caught by the police, separation from their families, limited access to a health care system, and exploitation from their employers. They face a "social survivalism", described by daily difficulties concerning housing, employment, health care, nutrition, etc. (J. W. Rosado & Elias, 1993). Despite these circumstances, sometimes Latin American women seem to find a sort of "blossoming" in their migration journey manifested through freedom, independency, physical security and job opportunities. This positive state of mind is also strongly supported by prayer and religion (Sangra Bron, 2006).

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[8] TOA.

[9] TOA.

Carbajal (2004) describes Latin American women as active individuals who participate in social groups or associations (e.g., gatherings, parties, church). In the same manner, they have the ability to achieve a "normal life" in secrecy, thanks to the reconstruction of their trust and identity through the performance of daily activities (taking the bus, going to work, buying groceries, having the children go to school) (Bolzman et al., 2007). They become part either of Latin American associations or associations for immigrants from all nationalities. For instance, in Lausanne, the "Mozaik" [10], has an important number of Latin Americans in its French classes. When its soccer team existed, it was mainly constituted of men of this population. Undocumented Latin Americans are often present in different sports, cultural, musical and dancing events from their community, which shows a good level of integration and dynamism despite the legal restrictions. In countries like Switzerland, the social and economic integration of undocumented immigrants depends on the social networks established between them and the members of the host society (Carbajal, 2004). However, in general, the integration of these families into the Swiss culture is minimal due to linguistic, economical and legal barriers. Likewise, the stereotype that Latin Americans carry does not facilitate their integration into the Swiss community, and much less when it is reinforced daily by the evocation of disasters, violence, or "cultural lag symptoms" (Gomez, 2005).

In 2004, females represented 64,5% of the Latin American immigration in Switzerland, which makes it an exceptional phenomenon in comparison with other world regions, where women represent about half of the migrant population (Valli, 2007). When children immigrate with these mothers, they are also exposed to similar life conditions, with the exception of education access, because the Swiss law gives the right to children under 16 to go to school no matter what status they belong to. However, their mothers often have an elementary education level, and most frequently come from underprivileged social levels (Carbajal, 2004). But not

[10] Mozaik *(Espace Hommes)*. It is an independent space provided by *Appartenances Association* that welcomes immigrants from all nationalities to gather, exchange, and share life experiences through formal and informal activities.

all of them do. Some have university degrees and work in non-professional activities in order to survive. Due to their illegal status, they are obligated to accept employment under inferior working conditions (Bolzman et al., 2007), to the point that we speak about "modern slavery" (Valli, 2003).

Illegal Latin American females are subject to jobs with high risk of exploitation, such as illegal domestic work and prostitution. For instance, in the region of Lausanne, sex workers are mostly of Brazilian origin (Stienen, 2003). At the same time, Latin American migrated women are potential victims of human trafficking (Chapot, Medico, & Volkmar, 2009). In this research, it is important to note that an important number of the participants of this study belong to the first risk group: illegal domestic work. Others belong to the legal Latin American residents (see *Chapter 2.4 Other Latin Americans Immigrants*). No participants belong to the second group: prostitution.

In a study made in Geneva Switzerland with 134 pregnant women (Wolff et al., 2005), 77% of them were from Latin American origin. As other members of their community, they had immigrated in the majority of cases for economical reasons. Just in a few cases, they had immigrated for educational purposes, for tourism, or to join a family member. Pregnancy and abortion seem to be significantly present in this population. According to the statistical analysis in the Canton of Vaud [11], Latin American females represent the second foreign population in Switzerland that seeks abortion. Almost 30% of women who abort are originally from South America (Carbajal, Pasquier, & Cand, 2008), which is quite significant, for a mostly catholic community with strong maternity values. These women, who find themselves pregnant, are often single and trapped between their feelings and their poor life conditions. Some others have a partner, but find themselves alone when being pregnant. In addition, the fact of having a child out of marriage is perceived as a "social sanction" (Carbajal et al.,

[11] Lausanne is located in the Canton of Vaud (one of Switzerland's geographic and political divisions of the French Speaking part of the country).

2008). A country offering legal abortion could represent an exit from the nightmare they have entered into. What drives these women to this unbearable situation of having to decide between their values and their life reality? According to the study conducted by Carbajal (2007) in Lausanne's region, many of these women are ignorant in contraception methods or inconsistent/inefficient in their use. Professionals interviewed for this project, expressed their astonishment of the lack of information or the erroneous knowledge related to the sexual education and contraception in Hispanic American women. Additionally, they think these females have good fertility, which clearly facilitates a pregnancy when taking no contraception.

According to the health professionals of *Water Point Association –Association Point d'Eau*, the institution that receives the largest number of undocumented Latin American in the region of Lausanne, since 2009 this community has new features in their migration path. The new immigrated Latin Americans, in their majority, do not come directly from their country of origin. After having legalized their residency status (permit or citizenship) in Spain, they escape the country's economical crisis and search for working opportunities in Switzerland. In this new migration series, it is stated that there are more men (contrary to previous migratory movements), but statistics have not been so far determined. These men often do construction work.

Despite these recent changes, during the last decade, Latin Americans in Switzerland have been principally represented by single women who often find themselves in a psychosocial and economic precarious situation (Carbajal, 2007) due to an illegal status. Nevertheless, their inner force is an enormous resource that helps them overcome their difficulties making them capable of adapting to a foreign country and of integrating to an occupational field. Latin Americans "are people who are constantly in movement, searching for paths and solutions, while they benefit from little assistance" (Rothenbühler, Burkhard, & Rothenbühler, 2007; Wolff et al., 2005).

2.4 Other Latin American Immigrants

Evidently, there's also a population of Latin Americans in Switzerland whose socio-demographic characteristics vary enormously from the ones described above. Many of them constitute official students (university's degrees), or employees frequently hired by international companies based in Switzerland. However, thanks to their financial stability, legal status, and easy access to the health care system, their social-cultural difficulties decrease. In addition, they often seek health care in other institutions, which in most cases are private. The Swiss government officially recognizes this type of Latin American immigrants.

While this type of legal Latin American immigrants happened to be the most represented in this study, they characterize a low percentage in Switzerland as previously mentioned in the literature, and as cited by health professionals in Lausanne. For this reason, this subchapter will be partially developed. Indeed, some documented Latin Americans in this research are constituted of immigrants who have been able to legalize their status, and had somehow experienced similar life conditions to the group previously prescribed.

According to Riaño (2003), family-related migration plays a more important role than employment in motivating documented Latin American women movements or permanency in Switzerland. A study conducted by this author in Bern illustrates that, at the beginning of 2000, marriage was the main reason for legal Latin American women to move or to stay in this European country. These females had either moved to Switzerland for studying reasons and had planned to return to their home countries before meeting their spouses, or they met their Swiss future husbands while these last were studying or working in Latin American. In comparison to the previous Latin American migrants who are mainly motivated by economic reasons, this group of "love migrants" seems to be motivated by family projects. A part from marriage projects, many immigrants coming from the South are driven by family grouping endeavors (Bolzman, 2007).

Whereas migration conditions seem ideal within legality, the slowness of the decision making process reflects their difficulty to separate from their cultural roots (Riaño, 2003). In

addition to the separation from their loved ones in their home countries, difficulties experienced by legal Latin American immigrants are characterized by the struggle to professionally integrate in the host country. Several are "employed at a level well below their qualifications or are excluded from the job market" (Riaño, 2003, p. 26). Others often face institutional barriers while their degrees coming from "undeveloped countries" are devaluated (Bolzman, 2007). In the case of females, they are often relegated to a housewife role that implies financial dependence on their husbands, which clearly affects their identity. Social informal networks become for them a formalized support to overcome social and professional integration barriers (Riaño, 2003).

2.5 Latin Americans' Migration Projects

From an anthropologic perspective, the migratory flows have existed from the beginning of times everywhere in the world. Man has always searched for means to improve his life conditions through a nomadic tendency (Valli, 2003). However, it is at the beginning of the 19th century that "migration have become globalized"[12] (Wihtol de Wenden, 2010, p. 21). This means, according to this previous author, that, today, almost every region in the world is concerned by the arrival, departure, or transit of foreign citizens. According to the International Office of Migration (IOM), migration is the movement of a person or group of people with the purpose of improving their material and social conditions, and their future personal and family life perspectives (OIM, 2010b).

Today, the Latin Americans' migration phenomenon in Switzerland, as in many other countries, is directed towards improving their life conditions and their families' lives in their home country (Sangra Bron, 2006). According to Bolzman et al. (2007), the project to return to their country of origin is omnipresent in their narratives. Both as a dream, a myth, or a

[12] TOA.

tangible project, shows a form of loyalty to their cultural roots and their families. As expressed by Ruben Blades (Panamanian social singer): "Everyone returns to his birth land, the unique charm of its sun, all return to the land where they lived ...". This rite of return has also been somehow demonstrated by the American theory of the "Salmon Bias", which states that Latinos with a more deteriorated state of health return to die back in their countries of origin (Turra & Elo, 2008), as a salmon returning to its birthplace in the river.

Latin Americans' migration project is founded by a "mythical hope of a heroic return"[13] (Métraux et al., 2003, p. 15). A heroic return represented by a modest financial success that would allow their dreams to become true. For example, to buy a house, open an independent business, or just assume the financial education of their children (Métraux et al., 2003; Staab, 2003). From another perspective, the migration project is determined by what (Gomez, 2005) calls "generational altruism": the belief in a better future for the children at the expense of personal sacrifice. Other migration projects are those considered by single women (with or without children), which consist of finding a man that could help them change their illegal status (Valli, 2007), and often, fulfilling their wishes of having a partner and establishing a family. Other women find in the migratory process the escape from romantic relationships that failed.

Latin Americans' common ideals and dreams help them progress on their often-shared migration project. Families and friends already installed in the foreign country meet the new arrival's basic needs and help them find employment and housing (Métraux et al., 2003; Valli, 2007). Their best survival resource in the new country is what Valli (2007) calls "the social capital": family, community and local supportive fellows.

On the other hand, the family member that is "lucky" to be part of a migration journey has a debt of reciprocity with his close ones left in the home country. A debt with those who are

[13] TOA.

waiting for his success in the "wonderful foreign land" in order to improve their economic resources. The Latin American who immigrates in difficult conditions should live not only under this pressure, but also often struggle with the stress of a host country that has exchanged his dream for a precarious life condition. Their living circumstances often stop them from building future plans, which clearly has psychological repercussions over the human being. For them, the future has a hypothetical character.

For Latin Americans, a family/friendship-focused orientation community by tradition, (Añez, Silva, Paris, & Bedregal, 2008; J. W. Rosado & Elias, 1993), an immigration endeavor will require even greater effort as it involves the separation from solid established cultural and family roots. Latin Americans families often live in the same homes, in the same neighborhoods, with the same neighbors, and the same friends for years and years. Children stay with their parents until marriage[14], or when moving out they will keep a close contact with them. In some cases, even after marriage, they will continue cohabitating in one of the parents' home. So, when it comes to migration, many sacrifices come along with the sadness of imposed good-byes.

3. Interpreters and Latin American Patients in Lausanne's Health System

Health Institutions in Lausanne, as others in Switzerland, have had to address many challenges during the last decades regarding cross-cultural health care. Migration waves coming into the country, suddenly presented health professionals with communication issues during sessions, while they had limited resources. In order to adapt to these strong migratory movements, the society reacted through the establishment of new health policies. One of them

[14] This costume has started to change in the last 10 years, but it has not become the norm to leave the parents home when becoming an adult.

was the Health Insurance Federal Law in 1994, known as LAMAL, which requested an obligatory insurance for every resident in the country. This insurance provides benefits in case of disease, accident or maternity (Confédération-suisse, 2013) for all residents no matter their origin. However, while the goal of this based insurance was to guarantee medical care to any person living in the country, the LAMAL contained underlying messages for health professional in terms of effectiveness: spend as little time as possible to get the most results. In consequence, the new Health Insurance Law renewed principles and practices, promoting competition between different health care providers, both public and private (Rossi, 2002). Despite these dynamics of rivalry, the health care institutions united their forces to provide migrants with their health needs and to address communication issues in therapy.

In Lausanne, on the one hand, basically 3 types of intervention systems were created to treat migrant patients according to their resident status. The first one called FARMED (which will be developed in the next paragraphs) takes care of asylum seekers. The second one categorized as an associative movement (e.g., *Water Point Association*), focuses on fulfilling the health needs of undocumented migrants among others. The third one is the above cited LAMAL that mainly takes care of legal residents (Rossi, 2002), even though all residents have the right to access it. On the other hand, interpreting services were developed to address communication needs.

3.1 Evolution of the Interpreting Services

The origin of the interpreting services in Switzerland is quite recent. While countries such as United States, Australia and Sweden addressed this subject in the 1970's, Switzerland manifested its interest around the 90's. The first interpreting project was developed in Bale in 1987 by the union of protestant churches. In 1990, the second one was created by the University Hospital in Zurich. Few years later, the interpreting services were solidified with the opening of the *Health Center-Migrants* in Geneva and the installation in Bern of an interpreting unit at the Red Cross (Métraux, 2002).

Appartenances Association and one of its founders (J-C. Métraux), were some of the pioneers of training in cultural interpreting in the French speaking Switzerland. Today, as already cited, *Appartenances Association* is one of the institutions that specialize in training interpreters to become professionals in their work field.

But the creation of professional interpreter services was not the only reaction to the increasing migration movements in the country. The health institutions created two types of networks to best meet the needs of patients with different cultural backgrounds in terms of communication: an intra-institutional and an inter-institutional network. The first one (intra-institutional) was an informal collaboration between employees from the same institution. This consists in using the colleagues' language skills to solve communication barriers present when providing services to migrant patients. These correspond to the *untrained interpreters*, according to Hsieh's classification. The second one (inter-institutional) is called FARMED, which is a network constituted of several private and public institutions.

While FARMED was not exclusively created within a perspective of easing health communication, overall it searches the goal of providing health quality to asylum seekers. It aims to control health costs of the asylum seeker community, while ensuring optimal care. To best reach its mission, the network considers some of this population's characteristics (cultural differences, migration journey, legal status in Switzerland, etc.), while assuring a training for all the participants implied in the treatment of allophones patients (Rossi, 2002).

The awareness of the necessity to not only translate words, but also to understand meanings, values and representations, continued growing with great importance. In 2004, the term *community interpreter* was adopted in Switzerland to formalize and precise the work performed by professional interpreters. Along with this, the Swiss Interpreter certificate was created thanks to the efforts of INTERPRET Association, which defended the idea of a trialogue in the health encounter accompanied by a co-construction of a common sense (Fleury & Fierro, 2009). The certificate is achieved once the future interpreter completes a specific training, 50 hours of working experience, and fulfills the criteria in linguistic skills in both languages (Interprèt, 2012). In 2009, an Interpreter license was established for those who

have completed the certificate, and would like to be trained to intervene in more complex interpretation situations. In addition to the certificate's requirements, supervision is needed for this new degree (Interprèt, 2012).

3.2 Type of Interpreters in Switzerland

In a study made by Eytan & al. on (1999), psychiatric services in Switzerland reported using, in the majority of the cases, *untrained interpreters* (e.g., health care staff) and *chance interpreters* (e.g., patients' family members or friends) while using trained interpreters in a low percentage. In another more recent study conducted in a Swiss hospital (Bischoff & Hudelson, 2009) results continue to show exactly the same: health professionals use *untrained interpreters and chance interpreters,* and rarely use professional interpreters. In this regards, the authors express their worry because these strategies of interpreting have been associated with poor quality health care. In addition, Bischoff & Hudelson's findings show that, between the 9 foreign languages spoken by the patients during their research, Spanish and Portuguese are the languages where *on-site interpreters* are the least frequently called, and where *untrained interpreters* are the most often used. Moreover, in private practice, some physicians in Switzerland state that the use of the interpreters is not always necessary as for example when treating minors infections (cold, ear infection, etc.) (Graz et al., 2002). According to Bischoff and Hudelson (2009), professional interpreters are used only as the last case, this due "to cost concerns and scheduling difficulties" (p. 1).

Few years after the creation of the FARMED network, a new type of interpretation services classification was born: *asylum seeker interpreters*. This group of interpreters was constituted of the same asylum seekers, but those who had adequate language skills in the local language in addition to the patient's (compatriot's) language. They were trained to translate during medical sessions. This new service allowed some asylum seekers to have some employment while the health institutions were helping resolve communication issues at a lower price. This type of interpreter does not encompass the Hispanic American community, as their migration conditions are accompanied by illegality rather than by political asylum.

Therefore, this example will not be used during this study. Nevertheless, this reminds us that other interpreter categories could be created when eminent needs exist and restricted sources are available, even though an awareness of its limitations is well known.

According to the survey conducted by Graz, Vader, & Raynault (2002) in one of the French speaking Cantons of Switzerland, 45% of physicians wish to have available a *telephone interpreter* and 58% wish to have available glossaries with phonetic terms and illustrations. While the majority has a preference for the presence of *community interpreters*, they believe these other alternatives are necessary, especially in emergency cases.

3.3 Lausanne's Health System

In Lausanne many of the institutions that collaborate with this project, if not all, are targeted by the undocumented migrants due to their social mission that searches to reach the deprived, while assuring them confidentiality. This means that there is already the existence of a *community vs. institutional alliance* before an *individual alliance* grows in the encounter between the Hispanic American patient and the health professional.

Within the optic of this research study, the following 6 health institutions in Lausanne represent Lausanne's Health System. These were selected due to the importance of their work provided to the Hispanic American Community and other migrant patients. In addition, some health professionals in private practice contributed to this project through their collaboration. The following presentation aims to illustrate the type of health services that they provide to the migrant community.

3.3.1 *Appartenances Association – Association Appartenances (Lausanne)*

It is a Swiss association that provides social and outpatient mental health services to migrants in Lausanne. The service of Psychotherapy for Migrants[15] offers psychological and psychiatric services to migrants in the region, including Lausanne. These services are offered by a multidisciplinary team (psychiatrists, psychotherapists, psychologists, ethnotherapists, speech therapists, interpreters) to children, adolescents, and adults through individual, family, couple or group sessions. Issues related to migration endeavors are especially treated for people from diverse origins that manifest mental suffering. Psychotherapeutic consultations are carried out in 63% of the cases with the help of a community interpreter (Association Appartenances, 2011). However, for the Spanish speakers, the presence of an interpreter is minimal because a bilingual therapist is often in charge of these cases. In addition, the Hispanic Americans represent a small percentage of the patients (4%). As already cited, the Association counts with an Interpreting unit that trains and certifies interpreters, while offering a pool of interpreting services in the region.

3.3.2 *The Policlinic: Department of Ambulatory Care and Community Medicine – Policlinique médicale universitaire de Lausanne (PMU)*

As a public institution in a country that values human rights, the Policlinic has gradually assumed socio-medical missions and helps especially people with low resources, vulnerable, and marginalized. Since 2000, the "Unit of Vulnerable Populations" (UPV) has been created to face the growth of migrants without legal status, asylum seekers, and indigenous marginalized. Generally, patients first meet a nurse with a prevention or treatment purpose. When needed, the nurse refers the patient to a general doctor, and consequently the doctor to a specialist when required (Bodenmann et al., 2003). In terms of this research study, two structures were involved: *General Consultation and Psychiatry of Liaison*. The second offers psychological / psychiatric services to patients who first seek services for physical problems or

[15] Translation in French: Consultation psychothérapeutique pour migrants (CPM).

have psychosomatic problems. The percentage of Hispanic American patients in this structure is significantly less representative than in the *General Consultation*.

3.3.3 Lausanne's Childhood Hospital – L'Hôpital de l'Enfance de Lausanne HEL

This health institution is dedicated to the care of sick infants, children and adolescents. All common illnesses of children including medical, surgical, psychiatric or psychosocial are supported. Assistance and support for families are also part of the priority tasks of the hospital, an institution with a strong social connotation, rooted in the community. Following the same parameters of the Policlinic, the Childhood's Hospital focuses on helping undocumented children, among others. The illegal status of these children is the result of the illegal immigration from their parents. In 2003, 80 to 90% of the patients (children) belonged to Latin American families, especially from Ecuador, Colombia, and Brazil, in that respective order (Valli, 2003). In 1997, studies demonstrated that the most significant difficulty between the therapist and the patient was related to barriers in communication due to the large number of foreign patients (Gehri et al., 1999). Thus, the Hospital created a service half a day per week in which the presence of a *community interpreter* was assured for several languages including Spanish. However, according to statements of health professionals of this institution in 2010, this space is no longer available for Spanish speakers due to a significant reduction in patients from Hispanic American origin during recent years.

3.3.4 The Department of Gynecology-Obstetric – Le Département de Gynécologie-Obstétrique DGO

It is a division of Lausanne University Hospital (CHUV) located in the French-speaking Switzerland. It offers services to women, men and couples during major changes in their intimate lives: pregnancy, fertility / infertility, child birth, miscarriage, abortion, sexually transmitted diseases, sexual violence and menopause. Two services collaborated with this research: *Family Planning and The Maternity's Polyclinic*. While the first one provides information on contraception, problems related to postpartum, infertility and abortion, the

second one focuses mainly in monitoring pregnancies and childbirth. In particular *Family Planning* works with many migrants in the region of Lausanne. For this reason, it offers informational materials translated into 10 languages (Département de Gynécologie Obstétrique/Planning Familial, 2008).

3.3.5 The Water Point Association – L'Association Point d'Eau

It is an area of health, care, and guidance to help people in precarious situation, homeless, jobless, marginalized, students, seniors, or inadequately housed. The Association offers a variety of health care services (dental, nursing, osteopathy, medical, psychological support, massages, etc..) and provides a structure to fulfill some basic needs of these individuals (e.g., showers and laundry). Since 1999, the Water Point is especially visited by undocumented people. Indeed, the Latin American patients represent 44% of nursing and medical services (Association Point d'Eau, 2011). From the 6 institutions involved in this project, it is the most frequented by the Hispanic American community.

3.3.6 Profa Foundation – Fondation Profa

It is a private non-profit foundation that meets health needs (as defined in the World Health Organisation) and refers to the declaration of sexual rights IPPF (International Planned Parenthood Federation). Its aim is to work to develop the quality of the emotional, relational, and sexual life of men and women at all stages of life. This is without discrimination of gender, identity or sexual orientation, and focused on promoting respect for their integrity. As a reference center in its areas of expertise, the Foundation has a desire for information and training. The assistance offered concerns: sexual and reproductive health, pregnancy, sexuality, couple relationships, and assistance to victims of crime. Two services collaborated with this research: *Sexual Health Consultation-Family Planning and Advise in Perinatology*. The first one provides services related to the emotional and sexual life, prevention of unwanted pregnancies, and sexually transmitted infections. Sexual health counselors and physicians are part of this service, which exists in all regions of the Canton of Vaud. Only medical consultations are charged, with preferential rates for young people. The second one

offers information, support, and guidance to prospective parents (mothers and partners) on pregnancy, maternity, and paternity. It exists in all regions of the Canton of Vaud as well. The tandem midwife counselor and social worker in perinatology feature interviews taking into account the personal, family, social, emotional, and psychological aspects connected to the situation. These consultations are subsidized and unbilled to the expectant parents. The program *Migration and Intimacy,* in collaboration with the Association Fixed Point – Association Point Fixe, was created with the objective of preventing non-wanted pregnancies and sexually transmitted diseases in communities of migrants originally from Latin-America and sub-Saharan Africa (PROFA, 2007). Today the program continues its existence, but directed to migrants from all cultural backgrounds, and in partnership with different health programs in the region. In 2010, Profa foundation created an internal document with a detailed procedure to find and have access to professional interpreters, this with the purpose of improving communication quality in their services.

3.3.7 Private Practice – Cabinés Privés

In total, 3 private practice therapists that provide psychiatric / psychotherapeutic services in Spanish also collaborated in this research. 1 patient treated by a physician in private practice participated as well.

The following Table (2) illustrates the institutional and private framework where I collected my data. There exist other antennas in some health services providers that are not named because they were not involved with this project.

Table 2. Health Institutions in Lausanne that collaborated with this project

Psychological or Psychiatric Services/ Psychological support	Medical and Social Services
1. **Appartenances Association –** Association Appartenances (Psychological and psychiatric services)	
2. **The Policlinic –** PMU Department of Ambulatory Care and Community Medicine *Psychiatry of Liaison* (Psychiatric services)	2. **The Policlinic**- PMU Department of Ambulatory Care and Community Medicine *General Consultation*
3. **Water Point Association –** Le Point d'Eau (Mainly psychological support and some psychiatric services)	3. **Water Point Association –** Le Point d'Eau (Principally nursing services)
4. **Profa Foundation –** Fondation Profa *Advise in Perinatality*: pregnancy, maternity-paternity (Information and medical, psychological, and social support during pregnancy)	4. **Profa Foundation** – Fondation Profa *Sexual health consultations and Family Planning* (Sexuality, emotional life, and procreation information/prevention)
	5. **Lausanne's Childhood Hospital** - L'Hôpital de l'Enfance (emergency and medical services for children; social consultation for their families)
	6. **Department of Gynecology Obstetric –** DGO Département de Gynécologie Obstétrique *Family Planning and the Maternity's Policlinic*
7. **Private Practice** (Psychotherapeutic services)	

3.4 Health Issues of Latin American Immigrants

Migratory processes for people from all nationalities around the world imply high degree challenges that put at risk the mental health of individuals. Confrontation to racism, language barriers, work and housing problems, isolation, discrimination, identity problems, and acculturation (Wassermann, 2012) are just some of them. In today's world, for millions of people, migration brings with it a high level of stress that could exceed "the human capacity of

adaptation" (AteneaNetWork, 2010, p. 1). When the migration circumstances occur in extreme situations, individuals become vulnerable to the Immigrant Syndrome with Chronic and Multiple Stress (Achotegui, 2004). According to this author, this syndrome's name, known at *Ulysses*, was inspired from the Greek hero who suffered countless adversities while being in foreign lands faraway from his loved ones. The characteristics of *Ulysses syndrome* are sense of loneliness, sense of despair and failure, confrontation to survival, and afflictions caused by physical dangers (e.g., fear of detention and deportation). From a psychopathological point of view, this syndrome includes a combination of symptoms from different diagnostics: depression, anxiety, and psychosomatic and dissociative disorders. If we look at the Latin American immigrants, illegality could be a factor that predisposes this community to experience this syndrome. However, from my knowledge, no studies have been developed in Switzerland concerning this subject. Subsequently, what are the known medical and psychological reasons that drive Latin American patients to request health services?

As it relates specifically to Latin Americans immigrants in Lausanne, the main causes for seeking health are difficulties associated with the digestive and osteoarticular systems (Bodenmann et al., 2003). During this time period, psychiatric issues were one of the last reasons for consultation, which is not surprising due to the prevailing stereotype in which psychological problems are associated with shame and are socially criticized.

In more recent years, the main diagnoses in Latin American patients have kept the same hierarchy (Bodenmann et al., 2010): digestive problems (17%), and osteoarticular (12%); with the exception of psychiatric problems (9%), which are currently more representative than dermatological problems (6%) in this population. These differences in mental health results (between studies in 2003 and 2010) could be the result of an increasing psychological or psychiatric demand. However, it is important to note that each research had a different objective: the first study evaluated the reasons for seeking health services, and the second one, evaluated the principal diagnoses. One could then infer that there are more Latin American patients diagnosed in Switzerland with psychiatric / psychological problems than the number of people in this community who initially request services for mental health reasons. This

testimony evokes a study in the United States regarding Latinos' health issues which states that mood reactions and psychological distress are two main reasons for this population to seek professional help (Alegria & Vega, 2001).

In fact, Latin Americans often present psychosomatic disorders exhibited through gastric and dermatologic symptoms (Valli, 2003). Would these digestive, skin, and osteoarticular problems be the call for help from a tide of anxiety and suffering? Are these psychosomatic manifestations the door to receiving professional help? According to Rodondi, Guex, and Vannotti (2005), doctors tend to focus on the patient's immediate problem, but there are underlying problems that must also be discovered and identified. According to different medical health professionals interviewed for this study, Latin American patients' underlying issues are often psychological. This means that Latin American patients (especially those in illegal status) have an on-going psychological problem that could be the underlying cause for their visit to the health professional. To request health services, it is always easier to have a medical reason than a psychological one, when one's community has strong stereotypes about people who request help in this last domain.

It seems that for the Latin American community the access to health care is easier through professions that do not imply a potential psychological stigmatization. For instance, statistics from *Water Point Association* prove that in their institution there are more psychological difficulties manifested by the patients at the moment of requesting services than the number of interventions in this domain (Association Point d'Eau, 2011). This means that there is a higher need for psychological intervention in the Latin American community than the level of treatments that actually take place. Isabel Sangra-Bron, a nurse in the association, states that psychological difficulties are often addressed by the nurses from a psychosocial standpoint while providing medical treatment.

At the same time, Latin Americans appear to more easily establish a collaborative alliance in the relationship with professionals that do not belong to the psychological sphere (Paris, Añez, Bedregal, Andrés-Hyman, & Davidson, 2005). According to J. W. Rosado and Elias (1993), during periods of stress, Hispanic Americans opt for collective support systems:

compatriots, family, friends, church and religion. These support systems often represent the first source of help when having emotional or physical difficulties, putting the health professional in a different priority list. This is especially true for urban and low income Hispanic Americans (J. W. Rosado & Elias, 1993) where psychotherapy is sometimes inexistent.

From the anthropological point of view, it is worth noting that health has an origin in the social context, and diseases don't necessarily have an individual nature (Rossi, 2003). An illness could also be a social construction. This can be the case when an individual is in an environment that invalidates, disqualifies and devalues him (Rossi, 2008). These are typically the conditions surrounding illegal immigrants. Suffering results from the reflection of sadness engendered by the escape from an inefficient socio-political system in their countries of origin, and by the arrival in a host country with migration policies that reject them. This highlights the importance of considering health from a systemic point of view, which encompasses the interaction between genetics, emotions, environment, economy, culture and the human mind (Rossi, 2008).

A large proportion of illegal immigrants have no health insurance to cover the high cost of health services in Switzerland. While the health insurance is a right, it is not a reality for everyone. Therefore, a visit to a health professional does not necessarily make part of their priority list, except in cases where an institution has easy access and financial coverage for illegal immigrants. Moreover, as Chavez (2012) shows in his study with Latin Americans in USA, undocumented immigrants had relatively low incomes and were found to use medical services less in comparison to legal immigrants and citizens. At the same time, they trust more clinic-based care when they do seek medical services.

Medical and psychological issues are strongly sculpted by the type of legal status and therefore by the patient's lifestyle. As Valli (2003) illustrates, undocumented Latin Americans often live 3 or 4 in one bedroom apartments, which frequently cause interpersonal problems. In addition, they are confronted by the need of changing homes on a regular basis to avoid being caught or denounced to the police, both of which cause a high level of stress. The

precarious and unstable housing conditions of illegal residents should have negative psychological effects as well.

In the group of legal Latin American patients, referrals in psychotherapeutic specialized institutions for migrants (such as *Appartenances Association*) are generally coming from recommendations of other compatriots who have had the experience of going through this institution. According to Cristina Masseri, psychologist and psychotherapist with extensive experience in psychological work with the Latin American community in Lausanne, the main reasons for this population to request services are family, couple and/or parent/son emotional difficulties, which are exacerbated by migration. These are relationships that have often faced a series of transformations due to separations and/or forced unions provoked by migration. For instance, this is the case of the mother who emigrates to Switzerland and years later brings her children forcing them to adapt simultaneously to a mother who "temporarily and emotionally abandoned them", and to an unknown country.

From a medical standpoint, it is important to highlight that Latin Americans are more predisposed to certain infectious diseases like tuberculosis, Chagas disease (cardiac and digestive severe complications), and risk behaviors (tobacco, alcohol and sexuality). For this reason, various studies in Switzerland with Latin American communities have focused on these topics (Bodenmann et al., 2010).

In Switzerland, many hospitals and institutions receive and treat the undocumented. However, only part of this population access the health system due to their fear of being denounced or of not being able to afford the costs (Valli, 2003). A big number of them go to sanitation services that are available in the region that assure their anonymity and provide them with basic interventions.

Now that previous chapters have introduced and described concepts, particularities and systems inherent to this research, the last Literature Review subchapter will bring the reader to the exploration of the main theme of this research's objective: The Therapeutic Alliance.

4. The Therapeutic Alliance

Several years ago, the relationship between the doctor and the patient was a subject of interest that was kept in the dark. We knew it existed, but it was somehow left apart (Junod et al., 1991). In the last few decades, this relationship has become a topic of main importance that is largely studied, especially regarding its efficiency in the therapeutic treatment. In psychology, this relationship known under the concept of *therapeutic alliance* was initially studied by the well-known Freud and, later on, approached from a more empirical perspective by Luborsky and Bordin (1979). The first pioneers of the *therapeutic alliance* were in a psychoanalytic orientation. For this reason, the term was often associated with mother child-relationship, transference, identification, ego functioning, and resistance.

In 1990, (Gaston) provided a theoretical and empirical review of the history of the alliance's conception. Thanks to his work, we could see that it was Zetzel who, in 1956, introduced the concept of "*therapeutic alliance*". One decade later, Greenson introduced the notion of "working alliance" which was employed in equal manner showing no relevant differences regarding their meaning. Years later, Gaston (1990) classified the "*therapeutic alliance*" and the "working alliance" separately. He stated that while the first one describes an affective relationship, the second refers to the patient's capacity to purposefully work in therapy. Today, the term "*therapeutic alliance*" seems to be more often used in the psychological domain, whereas in the medical field the term "physician-patient" relationship has more privilege.

The *therapeutic alliance* is a topic of main discussion due to its importance in predicting the psychotherapeutic success despite the type of approach or the type of treatment (Gaston, 1990; Horvath & Bedi, 2002; Luborsky, 2000; Martin et al., 2000). The *therapeutic alliance* is the best outcome predictor in several type of therapeutic settings (Despland, De Roten, Martinez, Plancherel, & Solai, 2000). Regardless the psychological intervention, the patient experiences the relationship as therapeutic when a good alliance is established (Martin et al., 2000). According to Kuenzli (2012), thirty years of research has constantly demonstrated that a positive alliance is the most reliable predictor in obtaining a good outcome in psychotherapy.

But, what does *therapeutic alliance* mean? Luborsky (1994) defined the helping alliance as "an expression of a patient's positive bond with the therapist who is perceived as a helpful and supportive person" (p. 39). According to Horvath and Bedi (2002), "the alliance refers to the quality and strength of the collaborative relationship between the patient and the therapist" (p. 41). When looking for a meaning in a common language, the word "relationship" seems to be the most frequently associated. While several definitions have been attributed to this concept, I identify with the one provided by Martin & al. (2000): the *therapeutic alliance* is "the collaborative and affective bond between the therapist and patient" (p.438). After all, this definition is the result of the fusion of Gaston's two separate classifications (*therapeutic alliance* + working alliance), and of Horvath and Luborsky's definitions.

Luborsky (1994) describes two types of therapeutic alliance signs from the patient's perspective: one based on the patient's perception of the therapist as helpful and supportive, and the second one based on the patient's perception of the therapeutic encounter as a helping relationship which involves group work from both sides. It is clearly observed that the second type represents a more desirable active role of the patient. However, in certain contexts, it is often difficult to achieve this kind of involvement from the patient because he wants to "be cured" without having to do any changes or active participation (Galanti, 2008). When working with populations of refugees, the active role of the patient is often limited, first of all, by his unclear knowledge of the therapist's function and, secondly, by his poor ability to engage himself in a psychological work due to traumatic experiences. In addition, it is important to realize that individuals in a state of crisis need to be leaded as their high stress level limits their thinking process and impairs their capacity of insight.

According to Luborsky (1994) the alliance is not always positive. There's also a possibility for a negative alliance. However, he states that the positive alliance is a better predictor of the therapy's outcome. Regarding the characteristics of the therapeutic alliance, it is an element of the relationship that changes overtime; that becomes stronger or weaker with the time. It is not "a steady state or linear phenomenon" (Horvath & Luborsky, 1993, p. 568). A study in Lausanne showed that the growing alliance improved better the patient's health

conditions than the stable alliance, independently of its strength (de Roten et al., 2004). The alliance can experience a momentary or definitive rupture during the construction and development of a relationship.

The therapeutic alliance appears not to depend on the quantity of sessions, but on the quality of the encounter. "The impact of the alliance has been demonstrated in treatment ranging from 4 to over 50 sessions" (Horvath & Luborsky, 1993, p. 566). As one study revealed (Ward, 2000) no significant differences were found between number of sessions and the alliance, which means that strength of the alliance is not related to the time. However, the type of alliance seems to be different according to the stage of therapy. At the beginning the patient's alliance focus more on help and support, whereas the sense of shared responsibility is more existent on later phases of the treatment (Bachelor & Salamé, 2000). Based on the patient's perspective, the alliance is largely shaped during the first therapy session (Sexton, Hembre, & Kvarme, 1996). "The quality of the therapeutic relationship is established early in therapy" (Bachelor & Salamé, 2000, p. 49).

The therapeutic alliance is a concept often associated with psychotherapy. However, it is not unique to the psychological context. A study in the United States with medical patients of different backgrounds concluded that "the working alliance can be measured in medical care and appears to be strongly associated with patient's adherence to and satisfaction with treatment" (Fuertes et al., 2007, p. 35). While in other health professions the notion of therapeutic alliance is taking more amplitude, it is still less common. Moreover, the therapeutic alliance can be approached differently depending on the practical domain. In the medical field, the doctor has a relationship not only with the patient, but also with his illness (Balint, 1957) during the healing process. From an anthropologic standpoint, the therapeutic alliance will imply a connection with the individual as well as with his humankind, cultural background, and era (Good, 1994).

DelVecchio Good and Good (1999) believe that the medical anthropology is a relevant science when studying doctor-patient relationships. These authors suggest that the study of the doctor-patient relationship automatically involves a study of doctor-patient communications,

and this could be reached through "clinical narratives". Clinical narratives denote the understanding of the patient's description of his experiences, not only as the result of an individual process, but also as the result of social and cultural processes. The patient-doctor relationship is influenced "by domains beyond the actual dyadic interaction in clinical settings" (DelVecchio Good & Good, 1999, p. 247). Some of these domains are culture and medicine (e.g., medical education and professional competence, culture and clinic), local and global worlds of biomedicine (e.g., political economy of health services), societal culture of medicine/illness/healing (conceptual relationships of mind and body) and clinical narratives.

In regards to triadic interactions, several studies have extended the knowledge about therapeutic relationships with three participants, but from a family perspective. On the one hand, research has been conducted to explore the therapeutic process and development of alliance in a triadic relationship in family or couple therapy (Favez & Frascarolo, 2011). Within this context, de Roten, Fivaz-Depeursinge, Stern, Darwish, and Corboz-Warnery (2000) defined the communicational alliance as "the coordination of individual affective involvement behaviors of all of the partners in the therapeutic group" (p. 31). On the other hand, studies have been developed aiming to analyze the triadic alliance within the family sytem. These triangular relations consisting of father-mother-child are studied during the first years of life as well as how the prenatally unit is constituted in the triad (Corboz-Warnery & Fivaz-Depeursinge, 2001). Indeed, there exists a Study Family Center (Centre d'études de la Famille) in Lausanne, where its research unit is interested on the development of communication within the family, the impact of family dysfunction on the individual, and the impact of the pathology of one of the members on the whole family (Institut Universitaire, 2012).

The triadic therapeutic alliance has been considered as well from a collaborative view between two health professionals that treat the same patient. Kahn (1991) sheds light on the importance of establishing a three-way therapeutic alliance in split treatment. This type of treatment refers to a patient that simultaneously sees both a psychologist and a psychiatrist.

4.1 Therapeutic Alliance Factors

Based on Luborsky's research results (1994), the therapist can facilitate the therapeutic alliance through his behavior. He also indicated that similarities between the therapist and the patient may facilitate the construction of the alliance. On the contrary, Hersoug, Monsen, Havik, and Høglend (2002) found in their studies no association between alliance and similarity of personal characteristics between the therapist and the patient. However, they found a link between similarity of values and alliance when rated by the patient. Horvath and Bedi (2002) identified therapist factors such as professional skills and training, personal aspects, openness, ability to convey understanding and establish empathy. While they believe that trained therapists are more likely able to establish therapeutic alliance with severely impaired patients, they indicate that there is no correlation between professional education and the quality of the alliance. The Lausanne Early Alliance Research Group (Despland, de Roten, & Stigler, 2003), found that the therapist's experience plays an important role in the establishment of a good therapeutic alliance. Results from their Brief Psychodynamic Investigation technique (IPB)[16] show that the alliance does not evolve in the same manner depending on the therapist experience. The level of alliance seems to progress in a linear way for the experienced therapists. On the other hand, for the not experienced ones, the alliance seems to grow in a linear way until the third session and then decrease between the third and the fifth session.

The factors that may increase the therapeutic alliance according to the patient's perspective are showed in Bachelor's findings (1995): *nurturing* (exemplified by trust, respect,

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[16] The IPB technique is a brief psychoanalytic and therapeutic method of investigation developed in 1998 in Lausanne (Switzerland) with the purpose of gathering during the period of the first 4 sessions, the conscious and unconscious motivations that drive the patient to seek for counseling. The focus of this method is giving to the relational dynamic built between the patient and the therapist during the first moments of contact. This relational dynamic permits to establish a psychodynamic hypothesis linked to the patient's current crisis.

nonjudgmental attitude, attentive listening, friendliness, and empathic understanding) was the principal ingredient when creating a positive alliance with the therapist and, in consequence, a conducive environment for self-disclosure. Other key factors described by patients and cited by Bedi, Davis, and Williams (2005) are relatively close to a basic human contact (e.g., eye contact, smiling, warmth, identifying feelings and encouraging, etc.) at least view from an western society standpoint. Likewise, Posada Saldarriaga (2009) states that the doctor-patient relationship is based on kindness, tolerance, understanding, respect and acceptance of the patient's differences. In the family therapy field, patients perceive empathy, active and patient listening, understanding, sincerity, honesty, caring, etc., as the important aspects of their therapeutic relationship (Ward, 2000) showing no significant differences in comparison to individual therapy.

Concerning other therapeutic alliance factors, research in psychotherapy demonstrated that therapeutic alliance has an important impact on symptom change during treatment (Polaschek & Ross, 2010; Rogers, Lubman, & Allen, 2008). Conclusions from The Lausanne Early Alliance Research Group state that the positive evolution of the alliance during the course of treatment is connected with the reduction of symptoms and the improvement of the overall functioning as well as with the treatment satisfaction (Despland et al., 2003). Safran and Muran (2005) describe the therapeutic alliance as motor and essential component of changing processes in therapy. According to Thompson (2003), patients make more personal changes when they have created strong relationships with their therapists. The relationship with the therapist is therapeutic itself (Martin et al., 2000). In consequence, the therapeutic alliance is an integral part of patient change (Thompson, 2003). In any case, the second predictor of success in therapy is the rapid improvement of symptoms (Kuenzli, 2012). Mauksch, Dugdale, Dodson, and Epstein (2008) consider that rapport building and acknowledging social/emotional concerns may help improve quality of care and thereby its efficiency, which could be translated into symptom change.

From another point of view, research results from a university setting indicate that the bond component of the therapeutic alliance is predicted by "the extent and quality of the

therapist's social network" (Dunkle & Friedlander, 1996, p. 459). This means that therapists with personal support (e.g., family, friends, colleagues) could develop better skills to create therapeutic relationships early in therapy. On the patient's side, Horvath and Bedi (2002) identified three patient factors that impact the alliance quality: problem severity, type of impairment, and quality of object relations or attachments. For instance, difficulties in developing an alliance were identified in patients with borderline and personality disorders (e.g., Lingiardi, Filippucci, & Baiocco, 2005) as well as in criminals, homeless persons, and some drug dependent populations (e.g., Barber, Connolly, Crits-Christoph, Gladis, & Siqueland, 2009; Florsheim, Shotorbani, Guest-Warnick, Barratt, & Hwang, 2000).

Within the topic of object relations and therapeutic alliance, Kanninen, Salo, and Punamäki (2000) described three type of attachment patterns: a) autonomous, individuals characterized by coherence and integration and who easily establish trust, proximity and mutuality in intimate relationships; b) dismissing, individuals who tend to find their relationships problematic, and tend to be avoidant; and c) preoccupied, individuals enmeshed in their relationships who often mix current with past ones. The analysis of their study showed a correlation between attachment patterns and working alliance in trauma therapy for victims of political violence. The results indicate that, for the autonomous type, alliance decreased during the middle of therapy but increased back to his initial level at the end of it. For the preoccupied individuals, alliance dropped significantly during the middle of therapy but increased even more drastically by the end. On the contrary, for dismissing individuals, alliance was similar at the beginning and in the middle, but then it dropped down at the end.

From the same perspective, Rieben (2012) states that the ability of the patient to establish a therapeutic alliance with his therapist is influenced by the type and quality of attachments (e.g., secure vs. insecure) established in his relational environment, especially while being an infant. A patient with a tendency to create interpersonal secure attachments might more easily develop a therapeutic relationship with his therapist. Results from Thompson's study (2003) suggest that the therapeutic alliance is equivalent to the concept of "attachment relationship". In reference to the attachment theory, this means that the relationship with the therapist would

require a "secure base" to develop. While this conceptualization was originally used to described mother-child relationships, this last author considers pertinent its application to therapy. A secure attachment of the therapist and the patient promote the development of the therapeutic alliance (Navia & Arias, 2010). According to Raval and Maltby (2005) in all therapeutic perspectives there is some acknowledgement that the therapeutic relationship must feel safe and reliable enough to facilitate meaningful disclosure (Raval & Maltby, 2005, p. 69).

Research has shown that safety/security represents an important element in monolingual/monocultural settings (Thompson, 2003) as well as in bilingual/multicultural settings (Boss-Prieto et al., 2010). However, it seems that its meaning varies from one framework to the other. In the first setting, patients refer to safety as the secure feeling of confidentiality, and non-judgmental attitude, as well as to a possible return to therapy if needed (Thompson, 2003). In the second setting, the patients' meaning of safety refers more to acceptance, integration and protection. In addition, its definition can be sculpted by the person's social-economical status. For instance, illegality could bring in patients a special need of security, not only regarding what they say, but also who they are. Furthermore, "both patients' and therapists' personal histories have some influence on the capacity to develop a good therapeutic alliance" (Horvath & Luborsky, 1993, p. 566). In the same line of thought, Bordin (1979) affirms that therapist and patient bring to the therapeutic relationship a personal history that influences their interactions.

4.2 Therapeutic Alliance in Cross-Cultural Health Care

In cross-cultural health practice, the construction of the therapeutic alliance is accompanied by vital elements that influence the flow of the interaction, like language, cultural beliefs, representations, and traditions; these are in addition to the experiences linked to the patient. Socio cultural differences between mental health providers and patients can lead not only to communication difficulties, but also to relationship barriers (Takeuchi, Sue, & Yeh, 1995). In a therapeutic setting, misunderstandings due to socio cultural differences affect

the interactions "from mild discomfort" to "a major lack of trust that disintegrates the therapeutic relationship" (Carrillo, Green, & Betancourt, 1999, p. 830).

In a plural society, where several ethnic groups coexist, therapists are daily confronted to the challenge of establishing therapeutic bonds with people of diverse backgrounds. According to Rossi (2003), globalization requires that health professionals continuously adapt the interactions that they establish with diverse patients. These interactions, and the way the patient responds to them, are highly dependent on the pre-migration (individual specificities), the migration (trajectory) and the post-migration (integration and organization in the host country) conditions of the patient.

Within a cross-cultural perspective, an essential point in the therapeutic encounter consists in approaching the patient's experience with "openness, wisdom and humility" (Coleman, 2000). Likewise, Shonfeld-Ringel (2001) puts forth empathy, and mutuality as the main features when establishing a therapeutic alliance in multicultural practice. These features help the search for mutual accommodations that facilitate an adjustment between therapist and patient. In regards to the communication, Shonfeld-Ringel (2001) argues that expressions, patterns, signals, silence, etc., are indispensable in the definition of cultural sensitivity and in the cross-cultural working alliance because all these concepts underscore the importance of facilitating a mutual learning of perceptions and experiences. In order to have an effective and meaningful treatment, for both the health professional and the migrant patient, the inclusion of the sociocultural context of this last one must be considered (Leanza, 1998).

Coleman (2000) in an effort to apply general perspectives of the therapeutic alliance to the multicultural practice, he classifies the alliance between the therapist and the patient on two types: rational and emotional. While, the rational alliance refers to an agreement (goals, tasks, and roles) the emotional refers to the quality of the bond. Perhaps, while the rational alliance is more explicit, the emotional alliance is implicit and has a latent nature. At the same time, while the rational and emotional alliance are not unique to a cross-cultural setting, its establishment in this particular encounter may require a greater investment to avoid misunderstandings regarding meanings, exchanges, interpretations, and expectations.

However, health professionals are often taught to move away from the emotional alliance by an education that focuses on a rational alliance. They are supposed to have no affection for the patient, to be neutral, to be empathic but not emotionally touched by his story, to not physically touch the patient, to not accept any kind of gifts and, in consequence, to prohibit the reciprocity coming from the patient other than his "payment" for the session. This phenomenon could be explained by the term "Potlatch"[17] used in the health context by Métraux (2011), psychiatrist in Lausanne (Switzerland) with ample experience in working with migrants. It is the infinite power position often taken by the practitioners, which prevents any reciprocity in regards to what they could receive from the patients. The lack of reciprocity spurs the existence of an asymmetry which can go in detriment of the therapeutic alliance, especially when working with migrant patients. The symmetric approach facilitates a human being connection with the often linguistically and socially disqualified immigrants (Ronsenbaum, 2003). Nonetheless, in reality, the doctor-patient relationship is essentially asymmetric. The penetration to the medical universe implies already a confrontation to unequal positions (Singy & Weber, 2001), between the one who carries the knowledge and has the power to heal, and the one who is helped.

Métraux (2011) proposes certain elements of the alliance, evoking the topic of equality. He states that the alliance is built based on a *balanced reciprocity* accompanied by *a precious speech,* notions that involve a more emotional alliance. A *balanced reciprocity* means equal giving-receiving in the therapeutic relationship. It is the equivalence between what each partner gives and receives. "The alliance is woven of balanced reciprocity" (Métraux, 2011, p. 177). Therefore, a symmetric position instead of an expert position in relation to the patient will facilitate the alliance with migrant patients. By *precious speech,* the author refers to those

[17] Potlatch: "This term comes from the work of anthropologists with some Indian communities in North America. It describes an exchange where an overabundance of presents prevents any equivalent gift-exchange or any reciprocity: the donor then becomes the holder of an infinite and undeniable power" (Métraux, 2011, p. 171). (TOA).

words that go beyond the basic use of communication and the literal content. They are part of the person's identity, belief system and values; they express recognition. For instance, the patient's suffering shared with the therapist makes part of a precious speech, but so does the type of answer or reaction that the therapist gives back to the patient. The fact of recognizing the feelings of exclusion that an illegal resident has while not being able to find a job or housing, allows the establishment of trust, basic element of the alliance. Only a therapy funded on recognition and gratefulness will help treat families touched by the social suffering (Métraux, 2011). According to this author, precious speech helps to build and nurture the therapeutic alliance.

When referring to alliance disagreements, in cross-cultural therapy it seems that micro ruptures are more likely at the beginning phase due to misunderstandings associated to cultural variation and to asymmetrical power relation (King Keenan, Tat Tsang, Bogo, & George, 2005). Concerning misunderstanding associated to cultural variation, this topic was already treated in depth in *Chapter 1.1 The Interpreter*. Regarding asymmetrical power relations, the authors refer to the patient's historical and current discrimination experiences with other health professionals and/or other people in position of authority, which could be clearly the case for illegal immigrants or asylum seekers. This means that, for example, an immigrant not legally integrated in the society and politically persecuted might be predisposed to encounter more alliance micro ruptures in a new therapeutic relationship due to traumatic experiences with authority figures.

An important point to consider when referring to therapeutic alliance in cross-cultural health care is *Cross-Cultural Competence (CCC)*, which is defined as the capacity of the health professionals to work with patients from diverse origins (Bigby 2003 cited by Bodenmann et al., 2007). It is the ability to understand and perceive the patients in their own world and context and react adequately (Althaus et al., 2010). This conception of *Cross-Cultural Competency (CCC)* is similarly evoked through the notion of *Therapist Multicultural Competency (TMC)*. *TMC* refers to the therapists' self-awareness and sensitivity to how cultural backgrounds and experiences influence human values, beliefs (Carrillo et al., 1999)

and what is considered "normal" (Fuertes et al., 2006). According to Fuertes et al. (2006), their study of 51 dyads (of diverse origins) in the therapy setting, showed that patients perceive the therapeutic alliance as more trustful, understanding, and objective when *TMC* increases. Langer (1999) also believes that the awareness of culturally unique needs of the patient enhances a natural therapeutic alliance.

In helping relationships in a cross-cultural encounter, Leanza and Klein (2002) argue that is fundamental to recognize the illnesses and care conceptions as valid, as real representations for the patient and his family. When the health systems do not consider the patient's reality they end up offering services that do not correspond to the patient's perception and giving answers that he/she can't understand. These authors believe that a medical pluralism, which involves the complementary treatment approach provided by different health care professions, could be more adequate when treating migrant patients.

Likewise, the creation of a therapeutic alliance in cross-cultural health care is directly related to communication and its means. Teutsch (2003) considers that effective communication is essential for building the doctor-patient relationship and for delivering quality patient care. Health providers have noted that when patients feel comfortable, they are more willing to provide information or are more receptive to treatment (Hsieh & Jung Hong, 2010). In a study with underserved urban Hispanics in United States, David and Rhee (1998) concluded that "the foundation of primary care is the physician-patient relationship" (p. 397). They consider that a language barrier becomes a great obstacle in the creation of a therapeutic bond. The intercultural interpreting is a constructive stage in the relationship between an institution and a migrant (Es-Safi, 2000). The fact of having these services available to the community in the health institutions facilitates the establishment of a bond between the host country and different cultures that become part of it. The cultural mediation helps the patient's clear understanding of his illness or difficulties, and helps the compliance with his treatment. As Métraux et al. (2003) state, diverse studies of medical anthropology have underlying difficulties related to the patient's compliance due to incompatible representations of the illness between the western therapists and the foreign patients.

Considering that safety is an important dimension of the therapeutic alliance in cross-cultural health care (Boss-Prieto et al., 2010), as previously cited, providing a secure therapeutic setting for the patient might strengthen the relationship with him. This means a protective environment in which they could not only trust what is said, but where they could be themselves and be accepted as whom they really are. A secure atmosphere in transcultural therapy helps the weaving of the therapeutic relationship (Lévy & Sturm, 2002). Patients who perceive themselves worthy of love and support may be more likely to create emotional bonds with their therapists (Satterfield & Lyddon, 1998). This situation is difficult for an illegal immigrant whose environment is surrounded by uncertainty, precariousness and insecurity.

4.3 Therapeutic Alliance and the Latin American Community

A study conducted in the United States with Latinas of low socioeconomic status (mostly undocumented) indicates that similarity in language and cultural values may contribute to patient satisfaction and in consequence may increase therapeutic alliance. Services provided to Latin Americans in these different research sites were given with the assistance of competent bilingual/bicultural providers that are culturally trained. Results suggest that the provision of culturally competent health care may contribute positively the therapeutic alliance and treatment satisfaction (Paris et al., 2005). These findings corroborate those from Bagchi et al. (2011) with Spanish-Speaking in Emergency Departments in the same country. According to these authors, the provision of professional interpreters significantly increases satisfaction among patients and provider's as well. However, while the therapeutic alliance is often related to satisfaction and change, in this second study, the therapeutic alliance was not evaluated.

According to Bodenmann & al. (2010), patients of Hispanic origin appreciate a therapeutic relationship based on "mutual trust, respect and dignity" (p.105). Likewise, a therapist's warm and friendly relationship seems to be relevant to them, which would facilitate an alliance, and therefore, adherence to treatment. Similarly, clear and effective communication is a key element in building a good therapeutic relationship (Libertad & Grau

Abalo, 2004). This leads to believe that the therapeutic alliance is also closely linked to the quality of communication in the therapeutic encounter as viewed in the previous chapter.

Recapturing the topic of TMC (therapist multicultural competence), an open attitude towards cultural scripts and values are essential elements in treating patients from a different background. La Roche (2002) states that a cultural based understanding and interpretation of the patient's complaint is crucial in the creation of a therapeutic alliance. In the case of the Latino immigrants, *familism* and *allocentrism* are two important components of this culture. While *familism* "refers to a cultural value that involves strong attachments, reciprocity, and loyalty to extended family members" (La Roche, 2002, p. 115), *allocentrism* signifies the understanding of oneself through others or the emphasis on social relationships and groups rather than on individual ones. This means that a therapeutic approach focused on the family's symptoms, and not only on the individual's ones, may facilitate the establishment of a therapeutic alliance at least with female Latino patients. In this case, a systemic approach of the therapeutic alliance (Baillargeon, Pinsof, & Leduc, 2005) could be more pertinent, as it takes into account the relationship not only with the patient, but also with the system that surrounds him and makes part of his health issues. J. W. Rosado and Elias (1993) strongly recommend, with the Hispanic patient, a therapeutic networking that includes his extended family, religion and local community. Therefore, the therapeutic alliance would equally include the system to which the health professional belongs, for example the institution.

A qualitative study conduct by PROFA foundation (Carbajal & Pasquier, 2006), where 53% of the population were Latin Americans, showed that in the domain of sexual health and reproduction, the encounter between the doctor and the patient could be perceived as problematic by the latter. This perception is based on the feeling of not being heard, a feeling of having no choice, the discomfort of exposing their nudity, and the lack of understanding of medical jargon. In order to address this issue, the project *Migration and Intimacy* of this foundation concentrated on the importance of a human and intercultural relationship.

4.4 Therapeutic Alliance When Working with An Interpreter

A preliminary study in Switzerland has inferred that "there exists a therapeutic alliance between the therapist and the patient when working with an interpreter" (Boss-Prieto et al., 2010, p. 16). Nevertheless, the alliance meaning in the triad (presence of an interpreter) varies from one participant to the other. According to these authors, on the one hand, while therapists have a more intellectual point of view, patients have a concrete one. One the other hand, interpreters share their representations in equal manner with the therapists and with the patients. At the same time, this study shows that patients perceived themselves as less active in the establishment of the alliance because it is the therapist's job. This is especially common when working with refugees and non-psychological cultures because the therapist is perceived as an expert that has the knowledge to heal or the power to act.

According to Miller et al. (2005), the therapist-patient's bond is slower to form in a triadic setting than in a dyadic setting. This statement was guided by observations where patients created a prior bond with the interpreter. As a matter of fact, I will say that therapists also form a prior bond with the interpreter in order to reach the patient. However, while we know that the presence of an interpreter "represents a significant alteration to the traditionally dyadic therapy relationship" (K. Miller et al., 2005), we still have a limited knowledge of how the presence of an interpreter may affect the therapeutic alliance. The strength of the patient-interpreter relationship may threaten the therapist-patient bonding (Hsieh & Jung Hong, 2010).

Ronsenbaum (2003) refers to the interpreter as a "passeur de parole", an expression difficult to translate in its wholeness, but that I could best describe in English as "ferry man of speech", meaning: a person who passes words from one port to the other one, in this case, from one culture to the other one. Rosenbaum states that his presence in therapy is indispensable in weaving a therapeutic link in a cross-cultural setting. He helps the sharing of implicit speeches, representations and images, which are absent when no common language is present in the session. The "passeur de parole" prevents the reactivation of humiliations linked to the ignorance of cultural codes (Ronsenbaum, 2003), in consequence helping the creation of a trusting alliance.

Despite the potential contributions of an interpreter to the triadic relationship, "the presence of a third party may decrease the sense of privacy and intimacy" (Baker et al., 1998, p. 1469), consequently negatively affecting the relationship even when the interpreter and the clinician have been adequately trained. For this reason, in a triadic setting, the therapist should be attentive to the quality of his relationship not only with the patient and with the interpreter, but also to the relationship between the patient and the interpreter. The therapist has the challenge to observe and care for the dynamics of 3 pair of dyads present in the triadic cross-cultural encounter: therapist-interpreter, therapist patient and interpreter-patient (Goguikian Ratcliff, 2010). In bilingual health communication, the triadic relationship (therapist-interpreter-patient) implies "an inherent tension: the growth of one" dyadic relationship "may threaten other relationships" (Hsieh & Jung Hong, 2010, p. 195).

Raval and Maltby (2005) suggest that, in order to develop trust in the co-working alliance, it is necessary to do preparatory work between the practitioner and the interpreter where working expectations and styles are expressed. This trusting relationship needs to be also nourished after the session with a debriefing to facilitate the discussion of feelings, and the reflection on the outcome. Moreover, the bond between the therapist and the interpreter in terms of "adjustment" seems to be a matter of time and not necessary a matter of clarity in the instructions of how the interpreter should intervene. The longer the therapist and the interpreter work together the more common representations would appear regarding the health support provided to the patient (Goguikian Ratcliff & Suardi, 2006).

The definition of the interpreter's role and involvement would directly influence the type of alliance created in the triad. For instance, an interpreter submitted to the rigidity of a strict translation of words could not enrich the alliance creation through his life experience, cultural knowledge and professional/personal resources. A research study showed that the type of relationship established with the interpreter in the session depends on the therapist's expectations, which are at the same time guided by their professional specialty (Hsieh et al., 2012). According to Hsieh et al. (2012), the interpreters could be perceived as a) patient ally: interpreter who performs emotional and/or advocacy functions to facilitate patient health care,

b) interpreter as a health care professional: interpreters who are independent, neutral, faithful and accurate when translating from one language to another while having no emotional implication c) provider proxy: interpreters who share responsibilities to ensure the quality of care. Nursing professionals place more importance in having an interpreter as the "patient's ally" than mental health providers and oncologists (Hsieh et al., 2012).

Poor quality interpreting or lack of knowledge in using an interpreter may affect as well the therapist-patient relationship. For example, health professionals who have not been trained in working with an interpreter might lack skills to connect and communicate with the interpreter and the patient at the same time (Slomski 1993 cited by Baker et al., 1998). The therapist may look exclusively at the interpreter reducing the possibility to create an alliance with the patient through the complexity of the non-verbal communication. Baker's study conducted with Spanish-speaking patients searched to reveal the interpreter use and satisfaction with interpersonal aspects of care. Findings show that patients who did not have an interpreter when they thought they should have one were less satisfied than those who had one. However, patients who had an interpreter perceived their therapists as being "less friendly, less respectful, and less concerned for them as a person" (Baker et al., 1998, p. 1465) than patients who did not have one. However, 88% of these interpreters were non-professional underlining again the effects of poor quality interpreting.

THIRD CHAPTER: PROBLEMATICS, OBJECTIVE AND RESEARCH QUESTIONS

The therapeutic alliance is a topic that has been largely studied in psychotherapy and in monocultural and monolingual settings. When looking at its importance in terms of the outcome of the therapy, the knowledge of its elements becomes a central concept in health improvement. However, very few researches have explored the therapeutic alliance in a cross-cultural healthcare setting, where the therapist and the patient have no common language and/or have different cultural backgrounds.

For this reason, this study aims to explore the strength of the therapeutic alliance, and the factors that constitute the therapeutic alliance in a *dyadic setting* (absence of an interpreter) or *triadic setting* (presence of an interpreter), not only in the psychotherapy domain, but in any therapeutic encounter between a health professional and a foreign patient. To study the therapeutic alliance in cross-cultural health care practice, I will use the example of the Hispanic American Patients who request services in Lausanne's Health System.

Before listing the objective and research questions of this study, it is necessary to know the context in which this encounter will be studied: Hispanic American patients who seek medical, psychological/psychiatric, and/or social assistance in the region of Lausanne. Opposite to what might be suggested by an "individualistic psychologisation", the context and history are key concepts when studying a psychological aspect of the human being (Santiago-Delefosse, 2010). In this case, the therapeutic alliance could not be grasped in its integrity without considering the characteristics of the population and of the encounter with the therapist. Only an immersion in the field of study and a consideration of the individual's history and context could allow a deeper and lasting knowledge (Santiago-Delefosse, 2006). Consequently, the following contextualization questions will be explored.

1. Contextualization questions

a) Who are the Hispanic American patients in the health institutions?

b) How do health professionals perceive Hispanic American patients?

c) What are the greeting and communicating strategies with these patients?

d) How do health professionals perceive the dyadic and triadic work in therapy and the influence of an interpreter?

On the one hand, the encounter with the health professionals in the different institutions in Lausanne will allow answering these contextualization questions. On the other hand, initial information provided by the patients through the questionnaire will be the main source for answering question c). For more detailed description see the *Fourth Chapter Methodology, Instruments*).

2. Objective

The objective of this study focuses on studying the ***therapeutic alliance*** between different health professionals (whom I also refer to as therapists) and Hispanic American patients in a cross-cultural context. This encounter takes place in a health institution in a ***dyadic setting*** (without the presence of an interpreter) or in a ***triadic setting*** (with the assistance of an interpreter)**.** My goal is to study this relationship according to the patient's perception.

2.1 Research Questions

In a cross-cultural context:

a) Is the therapeutic alliance, between the therapist and the patient, stronger in a *dyadic setting* (without the presence of an interpreter) or in *triadic setting* (with the assistance of an interpreter)?

b) What are the factors that influence the patient's therapeutic alliance with the therapist and the interpreter?

c) Which are the factors that promote and demote the therapeutic alliance in a dyadic and triadic setting?

d) Can we identify a link between change (health improvement) and the therapeutic alliance as perceived by the patient?

e) Is there a relationship between the strength of the therapeutic alliance and the Hispanic American patients' different demographic data? Is there a relationship between the strength of the therapeutic alliance and certain variables inherent to the setting?

FOURTH CHAPTER: METHODOLOGY

In order to address this study's objective and answer its research's questions, a detailed research protocol was developed and validated before encountering the patients through a mixed approach.

In Lausanne (Switzerland), any study, no matter the discipline, that requests a patient's participation, requires a previous approval from *The Ethics Commission of Clinical Human Research*. This study was submitted in February 2009 and approved on the 24th of July 2009 by this commission. This means that it contains all the standards to approach the participants in an ethical and professional manner.

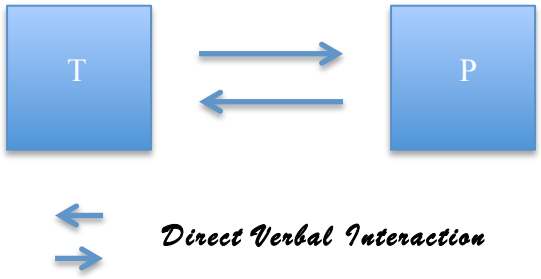
My direct contact with the participants had the purpose of evaluating the therapeutic alliance, according to their perspective, in a *dyadic* and *triadic* therapeutic setting. I will define these two settings before proceeding to the presentation of the participants.

1. The Dyadic and Triadic Setting

The cross-cultural health care encounter could take place in a *dyadic setting*, in the presence of a therapist and a patient who ideally share the same language. On the other hand, it could take place in a *triadic setting*, in the presence of a therapist, a patient, and an interpreter.

1.1 The Dyadic Setting

In terms of this research project, I will define the *dyadic setting* as the encounter of a health professional (therapist= T) and a help seeker (patient= P) with the purpose of helping and/or guiding this second one. Ideally, both speak the same language and therefore, they communicate directly as represented by Graphic 1.

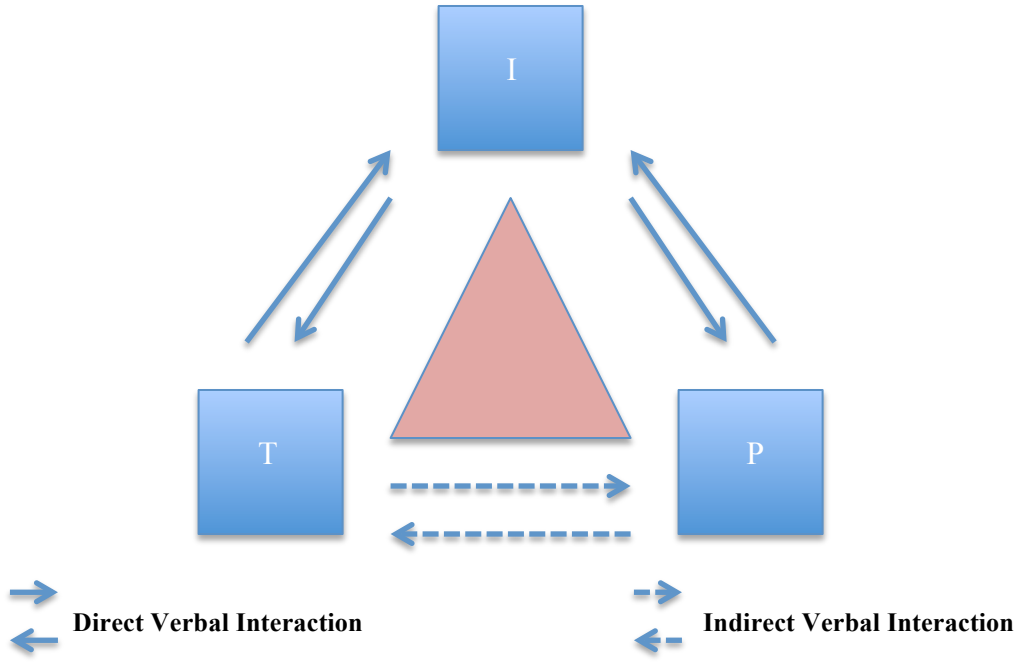


Graphic 1. The Dyadic Setting

A dyadic setting could be constituted of a Swiss therapist (or allophone therapist) and a Hispanic American patient. In the same manner, it could be composed of a Hispanic American therapist and a Hispanic American patient. This last case is also considered to be cross-cultural due to the Swiss framework that surrounds the encounter.

1.2 The Triadic Setting

The *triadic setting*, will be defined as the encounter of a health professional (therapist= T) and a help seeker (patient= P) who speak a different language, but are able to interact thanks to the collaboration of an interpreter (= I) who translates and whose role is determined by his type (see Hsieh's classification in *Chapter 3.2 Type of Interpreters in Switzerland*). The triadic frame consists of the exchange of interactions between 3 individuals, mediated by one of them (the interpreter), and with the purpose of helping and/or guiding another of them (the patient). While the therapist embodies the principal interlocutor as he leads the session, the interpreter symbolizes the center of this triangular relationship and functions as a regulator of the direct communication and as bridge for the indirect communication. Additionally, his central role facilitates the establishment of a bond between the therapist and the patient. It is important to be aware that in this particular situation there are no triadic verbal interactions, but dyadic verbal interactions in a triadic frame (see Graphic 2).



Graphic 2. The Triadic Setting

2. Participants

The participants of this research study are Hispanic American patients, originally from a Spanish speaking country in Central or South America. They are from all ages and legal status. They have emigrated to Switzerland or belong to a second generation of immigrants who reside in this country (e.g., born in Switzerland from Hispanic American parents). Participants seek health assistance in Lausanne's Health System (see *chapter 3.3 Lausanne's Health System)*. In cases where the patient was an adolescent (12-18 years), the participation was done with the parents or responsible adults' consent. There was no stipulation in the inclusion criteria regarding neither the stage of therapy nor the reason for seeking health care

services. The geographic origin and language were the only participants' variables that were controlled.

2.1 Recruitment procedure

At the beginning of this project, the sample size was previewed as following: a) questionnaire: 30 patients per institution to answer the QALM-PS for a total of 180 questionnaires b) Interview: 5 patients per institution for a total of 30 patients.

The participants were recruited through different health professionals (therapists) in the 6 health institutions and 3 private practices that collaborated with this project. Patients were invited by the therapists to fill at the end of the session a questionnaire that inquired about their relationship in therapy. Those who agreed were given an envelope containing a brief presentation of the study, an informed consent and the questionnaire in its Spanish version. The questionnaire was completed privately by the patients and given to the receptionist/secretary. They also had the choice to mail the questionnaire in a pre-stamped envelope. They were encouraged not to take it home so recent impressions from the session could be recorded and so that the participation rate would be higher. Along with the questionnaire, there was also an invitation to participate in the second part of this research (interview). Participants, who agreed to proceed, provided their contact information. A few weeks later, this researcher proposed the participants a face-to-face interview at their convenience. The whole period of recruiting (including the questionnaires and the interviews) was between March 2009 and August 2010.

In the end, 55 complete questionnaires were collected and 20 interviews were conducted. Recruitment difficulties will be evoked when citing the limitations of this study in the conclusion session.

2.2 Participant's Socio-demographic data

The following socio-demographic data refers to the 55 patients that answered the questionnaire. The participants are represented in most part by women (87%) which corresponds to n=48. They are principally from Ecuador (n=22) and followed by Colombia (n=9) and Chile (n=9) as illustrated in Table 3. Their median age was 36 years old, with a range from 14 to 58 years old. This is a representative sample from the Hispanic American community in Lausanne when we refer to references previously cited in the literature review chapter.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	**Colombia**	**9**	16,4	16,7	16,7
	Ecuador	**22**	40,0	40,7	57,4
	Uruguay	2	3,6	3,7	61,1
	Venezuela	1	1,8	1,9	63,0
	Argentina	3	5,5	5,6	68,5
	Chile	**9**	16,4	16,7	85,2
	Bolivie	2	3,6	3,7	88,9
	Paraguay	1	1,8	1,9	90,7
	Guatemala	2	3,6	3,7	94,4
	Nicaragua	1	1,8	1,9	96,3
	Mexico	1	1,8	1,9	98,1
	Dominican Republic	1	1,8	1,9	100,0
	Total	54	98,2	100,0	
Missing	99	1	1,8		
Total		55	100,0		

Table 3. Participants Country of Origin

Regarding the residence status, 65% have a legal status including residence permit, citizenship (nationality), or tourist visa (see Table 4). One case has a permit request under

legal status. Regarding the illegal status, 33% of the participants of this study are undocumented, of which two have a permit request, but under an illegal status. This data it is not representative of the characteristics of the Hispanic American community according to previous information presented on *Chapter 2.3 The Undocumented Latin American Immigrants*. This issue will be addressed in the discussion's chapter. Finally, 3 participants did not provide information concerning their residence status in Switzerland.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Permit	21	38,2	40,4	40,4
	Nationality	12	21,8	23,1	63,5
	Undocumented	15	27,3	28,8	92,3
	Permit request	3	5,5	5,8	98,1
	Tourist	1	1,8	1,9	100,0
	Total	52	94,5	100,0	
Missing	99	3	5,5		
Total		55	100,0		

Table 4. Status of Residence in Switzerland

Most of the participants (79%) had lived in Switzerland for 7 years or more and had attended health services in the same institution for almost 2 years, including (in some cases) interruptions in the treatment or new referrals. The number of times that the patients have met with the same therapist varies significantly from on case to the other. Nevertheless, in average, 31% have seen their therapist twice in a row. This may be explained by the fact that most patients were seeking medical help and, in general, medical services require fewer sessions than psychological services.

3. Instruments

The evaluation of the therapeutic alliance by the participants in regards to their therapists was done using two instruments: a) the first one, within a quantitative approach, focuses on a statistical and mathematical modeling, and b) the second one, within a qualitative approach, focuses on a descriptive an comprehensive model. These instruments are described in detail in the following sections, classified by their approaches.

3.1 Quantitative Approach : The QALM-PS Questionnaire

There exist several therapeutic alliance scales that have been validated and used worldwide. For example: a) System for Observing Family Therapy Alliances (SOFTA), b) The Working Alliance Inventory (WAI), c) The Pennsylvania Helping Alliance Scales, d) The Toronto Scales, e) The California Scales, d) The Therapeutic Bond Scales (TBS), e) The Vanderbilt Scales, (Martin et al., 2000), and f) The Assess Engagement at the triadic level (BCFS) to evaluate the triadic family alliance (de Roten, Darwish, Stern, Fivaz-Depeursinge, & Corboz-Warnery, 1999).

Nevertheless, these scales are not adapted to a cross-cultural setting that takes into account cultural and/or language differences, and the possible presence of an interpreter. Most of these scales were created in contexts with subjects with precise educational socio-cultural levels and with few migration experiences, in contrast with this study's sample. When considering the effects of globalization, the therapeutic systems are forced to adapt along with the movement of people (Sayokan, Musso, & Mulot, 2011), which equally requires a creation and adaptation of instruments. Difficulties have been reported by researchers who have attempted to translate basic questionnaires to use in different cultural frameworks than in those settings where these instruments were developed (Good, 1994).

For these reasons, the Therapeutic Alliance Questionnaire for Migrants – Health Professionals' version (QALM-PS) (see *Annex A*) was used as the quantitative instrument to

estimate the strength of therapeutic alliance according to the Hispanic American Patients' point of view. It is a self-administered questionnaire, containing questions that were pretested but not validated. It is intended to measure the therapeutic alliance in all health contexts, and not in a specific health discipline. The questionnaire was distributed one time, during a non-determined moment of the therapy/intervention. The goal was to test the questionnaire before proceeding to validation in a different study.

3.1.1 Structure of the questionnaire QALM-PS

At the beginning of the questionnaire, the following socio-demographic data was gathered: gender, age, country of origin, residence time in Switzerland, residence status, length of therapy/treatment, average of sessions with that specific therapist, the therapist's origin and first language (if Spanish speaking). The first chapter "*Alliance with the therapist"* aims to measure the therapeutic relationship of the patient with his therapist. This chapter is composed of 19 short questions followed by a 5 point Likert-scale response that goes from 1 (=Never) to 5 (=Always).

Only the patients who have an interpreter in their therapeutic setting answered the second chapter "*Alliance with the interpreter*" which is also composed of 19 questions and a 5 points Likert-scale response. This part has the objective of measuring the therapeutic relationship of the patient with his interpreter. Apart from the data related to the type of interpreter, results obtained during this chapter are not included in this study's analysis because they do not correspond to any of the research questions. Thus, this chapter could be useful for therapists wanting to explore the therapeutic alliance strength between his patient and interpreter.

The third chapter *"Evolution"* has the purpose of exploring the link between therapeutic alliance and change, in a dyadic and triadic setting. First of all, it determines by a yes/no question if the patient expects a psychological or physical change with the health services. If the answer is positive, 6 questions proceed to measure (with a 5 points Likert-scale) the change's level that the patient perceives in therapy regarding his health improvement.

This research investigation is an exploratory study as it relates to the quantitative approach. This means that it aims to deepen the knowledge in a new field. Results and analyses from this section could end in initial explanation attempts and eventually in models of theory, but does not provide absolute results. "Exploratory research is a methodological approach that is primarily concerned with discovery and with generating or building theory" (Davies, 2006, p. 1).

3.1.2 Origin of the QALM-PS

The QALM-PS is an adaptation of the QALM © *De Roten Y, Madera A, Boss-Prieto O.L, & Elghezouani A. Institut Universitaire de Psychothérapie, Association Appartenances et Université de Lausanne (2007)*. The QALM was built based on a preliminary study with migrant patients (Boss-Prieto et al., 2010). This preliminary study was conducted in 2004-2005 at the Appartenances Association in Lausanne. The participants made part of 9 triads that were constituted by 7 therapists, 5 interpreters and 9 Albanese patients. These last ones were mainly refugees or asylum seekers. Principal results have been cited throughout this manuscript and are summarized as the following: a) There exists a therapeutic alliance in a triadic-bilingual setting; b) the 3 groups of participants (therapists, interpreters, and patients) have different representations of the therapeutic alliance. Therapists have more intellectual representations and patients have more concrete ones. While the interpreters share representations with the other two groups, therapists and patients never had common alliance perceptions; c) therapists measured the alliance lower than the other participants, especially when it referred to them.

The creation of the QALM was inspired by the SOFTA (System for Observing Family Therapy Alliances) patient version, the WAI-S (The Working Alliance Inventory Short Form of Horvath) and The Penn Helping Alliance Scales of Alexander, L.B. & Luborsky, L. The QALM was created as an inter-institutional instrument, but it has not been validated. The QALM was designed to measure the therapeutic alliance only in a psychological setting. On the contrary, QALM-PS is intended for the evaluation of the therapeutic alliance in all type of health care context (medical, social, and psychiatric/psychological).

3.2 Qualitative Approach: Semi-structured Interview

A semi-structured face-to-face interview, based on an interview guide *(*see *Annex B),* was conducted with the patients who gave their agreement to participate on this second evaluation part after completing the questionnaire. A semi-structured interview is a research instrument composed of a set of questions that " allows interviewees to expand their answers and give complex account of their experiences" (Forrester, 2010, p. 78) while keeping the interview on track. In this research, the interview's goal was to obtain a more in-depth and descriptive perspective of the patient regarding the therapeutic alliance with his therapist and with his interpreter (in *triadic settings*).

The first questions were guided towards collecting data concerning their migration journey and reasons for seeking health services. While these interrogations do not answer directly the research questions of this study, this data illustrates the characteristics of the participants and the health encounter. These content will be presented in *the Fifth Chapter: Results* through two case examples in the form of *clinical vignettes*. A *clinical vignette* is a "brief, written case history" of a patient "based on a realistic clinical situation that is accompanied by 1 or more questions" (Veloski, Tai, Evans, & Nash, 2005, p. 152) to explore specific issues.

The other questions of the questionnaire, corresponding to the objective of this study, evaluated the patient's criteria to have a good relationship with his therapist (and interpreter in a triadic framework), moments of the sessions in which there was a good or bad contact with their therapist (and interpreter in a triadic framework), and motivations to continue or suspend therapy/treatment. This data is presented in the results sessions through positive and negative factors that facilitate or deteriorate the therapeutic alliance.

In terms of the qualitative approach, this research investigation is a phenomenological study. This means that it is a descriptive study of how individuals experience a phenomenon, in their singularity and in their contexts (Santiago-Delefosse & Rouan, 2001). In this case the Hispanic American patients' perspective on how they experienced the relationship with their

therapists, and interpreters (in a triadic setting) in their migration context and at a precise moment. It is important to recall that a semi-structured interview does not produce ultimate results, but obtains, throughout the narrative speech, specific points of view. "The interview is a form of social interaction" and "the way a person speaks about things depends on so many features of that interactional context" (Forrester, 2010, p. 84). Testimonies could change from one session to the other or from one setting to the other. "Single assessments of many facets of the participants' perceptions of the relationship cannot be assumed to be representative of their perceptions throughout the course of therapy, even though specific perceptions may persist over longer periods of time" (Bachelor & Salamé, 2000, p. 49).

4. Data Collection

The data collected for this study was gathered in two phases: ***the first phase*** implied the encounter with the therapists or health professionals. This information concerns the contextualization questions presented in the previous chapter. While this data does not make part of the objective itself, it will be included in the results because of its importance in situating the circumstances and the place where the therapeutic alliance is evaluated. The ***second phase*** involved the participation of the Hispanic American patients throughout a questionnaire and a face-to-face interview (for some of them) with the purpose of answering the objective and research questions of this study. The patients have the freedom to participate in each part. The fact of participating in the questionnaire did not engage them to participate in the interview. For this reason, there was an individual informed consent (see *Annex C*) for each evaluation tool.

4.1 First Phase: Encounter with the Health Professionals

First of all, I met with health professionals from each institution and private practice (see *chapter 3.3 Lausanne's Health System*) with the purpose of having a better knowledge of the field and engaging them in the research project. An informed consent was signed by each of

them (*Annex D*). The 11 professionals were represented by: 1 social assistant, 1 nurse, 1 physician, 1 nurse and midwife consultant, 2 family planning advisors, 1 psychotherapist, 1 sexual and reproductive health advisor, 2 midwife consultant, 1 psychiatrist.

Through a semi-structured interview (*Annex E*), I gathered information regarding the specific work done with the Hispanic American patients, the most frequent causes for seeking health services, communication means in the triadic and dyadic setting, and the health professional's perceptions on this community. This phase offers indispensable data for the contextualization of this research. The interviews were registered, but not transcript. The information gathered was then organized in tables guided by the following themes: relationship between the health institution and the Hispanic American community, treatment length, trajectory that leads the patients to the institution, specificities of the Hispanic American patients, most frequent reasons for seeking services, behavior/attitude during the session, moments in which they are more compliant or resistant, barriers and resources in working with patients from this community, interpreters request and remuneration, bilingual professionals' availability, perception of the dyadic and triadic work, link with the interpreter and his influence in the therapy.

4.2 Second Phase: Encounter with the Hispanic American Patients

From the 30 patients who gave their contact information, 20 met with this researcher and answered the questions corresponding to the semi-structure interview. The 10 others refused to participate for different reasons or did not come to the appointment. I proposed a meeting place that was convenient for both: participants and researcher (e.g., the patient's home or the University of Lausanne). Approximately, half of the interviews took place at the University and half at the patient's home. At the beginning of the interview, the first questions were focused on obtaining information regarding their migration journey and projects, the paths they followed to reach the different institutions or private practices, and their reasons for seeking health assistance. From my opinion, this facilitated the establishment of an initial alliance between the research and the participant, which opened the access to the following

evaluation. I have the impression that the language and cultural similarities between this researcher and the participants were also a positive aspect in the creation of a secure environment for them to talk. However, I often felt a need among these participants for psychological support. At times, the patients had the tendeny to transform the research interview into a therapy session. Once, I had a very disappointed female patient because her expectations were therapeutic. In other cases, participants asked me to see them again for a drink.

The personal data of the patients was kept strictly confidential and anonymous by this researcher. The patients were informed about this when they signed the informed consent. The questionnaires and the recordings will be destroyed at the end of this project after the oral defense with the jury. For this reason, no raw data from the questionnaires and interviews make part of this manuscript, and it will be only temporarily given to this thesis' jury.

5. Methods of Analysis

At the end of the nineties, there were debates between the qualitative and quantitative methods that were fueled by different epistemological standings. As explicitly described by their words, ones focus on the findings' quality while the others focus on the findings' quantity. Ones search for results' deepness and the others for results' amount. Researches from one approach would intensely criticize their opponents and vice versa.

> "Quantitative researchers typically criticize qualitative studies on the basis of being unrepresentative, using small samples, and not being replicable. Qualitative researchers argue that large quantitative surveys lack the contextual detail necessary to interpret findings, and they ask superficial questions with a limited predetermined range of responses on structured questionnaires" (Carey, 1993, p. 304).

Following these discussions, a tentative reconciliation between both approaches emerged through the use of mixed methods with the belief that the integration of approaches could promote the development of theories and sharing of knowledge (Bosisio, 2013). Today, the

use of mixed methodologies has been gradually expanded to several disciplines and domains to the point to which a scientific journal was created in 2007 in the United States.

Within public health, Carey (1993) argues that a link between both approaches guarantees a more effective study of cultural factors. From my point of view, the quantitative and qualitative approaches are inseparable. While quantitative interpretations could illustrate the description in qualitative data, qualitative readings could enrich the complete understanding of quantitative data.

"In the area of communication, an adequate quantitative/qualitative mix is essential in obtaining reliable data" (Paillé & Mucchielli, 2008) as well as an input of medical anthropology when working with migrants to understand health definitions in a variety of cultural and social settings (Helman, 2001).

5.1 Mixed Methods Approach

The mixed methods approach involves the collection and analysis of quantitative and qualitative data. The integration of both type of data is necessary to "provide the most complete analysis of problems" (Creswell & Plano Clark, 2007, p. 13) and to strengthen the weaknesses of separately applied methods (Creswell & Plano Clark, 2007). Indeed, mixed methods could bring the strengths of both types of approaches. On the quantitative side, evaluation tools allow reaching a larger population. Results imply a more universal language, especially when using descriptive statistics, because frequencies and averages are used in common speeches. On the qualitative side, evaluation instruments facilitate the expression of the participant, while analyses stay close to his testimony and ideas. The interaction and dialogue between the researcher and the participant enriches the content and depth of the answers provided. Misunderstandings might be clarified in comparison to a quantitative self-administered instrument.

The mixed methods ***triangulation design-convergence model*** was chosen for the analyses of this project "to obtain different but complementary data on the same topic"

(Morse, 1991, p.122, cited by Creswell & Plano Clark, 2007) when answering the research questions. This design is characterized by the collection and analysis of "quantitative and qualitative data separately on the same phenomenon" (Creswell & Plano Clark, 2007, p. 64). Then different results are merged during interpretation by comparing and contrasting their differences and similarities. The time for the data collection is sequential (qualitative following quantitative) and the weighting regarding its importance is equal. The triangulation method design has been implemented by Kopinak (1999) when studying the refugee well-being. Carey (1993) applied it to the integration of cultural factors into public health.

For this research, the complementary data implies the use of two instruments from different methodological approaches that search to identify the factors that influence the patient's therapeutic alliance with his therapist and interpreter (in some cases) in a cross-cultural health practice. While the quantitative instrument intends to provide, in addition, data on the strength of the therapeutic alliance, the qualitative instrument expects to offer deeper information on the alliance factors. It is worth noting that the qualitative data was gathered before the quantitative data was analyzed. This means that analyses were performed only when all data was collected.

The stringency of this mixed study is supported by a) an intentional collection of both quantitative and qualitative data; b) the researcher's known need of complementarity data to explore the strength and quality of the therapeutic alliance in cross-cultural health care practice; c) a detailed description of procedures; and d) the development of good conclusions or inferences (Creswell & Plano Clark, 2007). The challenges of this design will be addressed during *Chapter 7: General Conclusions*.

5.1.1 Quantitative Method

The data obtained through the 55 questionnaires was analyzed with the statistics software of SPSS. This software is a tool for managing and analyzing quantitative data. From a statistical point of view, in this research project the distribution of the results was not normal (results have the tendency to group in the same value of scale). For this reason non-parametric

tests where used for the analyses, specifically the Mann-Whitney U test, Spearman test, and Kruskal-Wallis test were used. The Mann-Whitney U test "works by looking at differences in the ranked positions of scores in different groups from lowest to highest" (Field, 2009, p. 548). A lower mean rank represents a group with the greatest number of low scores. The Spearman test is a correlation coefficient for non-parametric tests. The correlation coefficient measures the relationships between variables and how one affects the other. "We are interested in whether changes in one variable are met with similar changes in the other variable… (Field, 2009, p. 167)". The theory of the Kruskal-Wallis test is very similar to The Mann-Whitney.

5.1.1.1 Validity criteria of the quantitative evaluation phase

Based on Cronbach's alpha (α), a coefficient of internal consistency, the questionnaire QALM-PS has good reliability. This means that all the items measure the same latent variable, in this case the therapeutic alliance. When replacing the "missing values" for the mean, the results are still similar.

	Cronbach's coefficient (Missing values included)	**Cronbach's coefficient** (Missing values replaced by the mean)
First Chapter *Alliance with the therapist*	α = 0,712	α = 0,714
Second Chapter *Alliance with the interpreter*	α = 0.908	α = 0,782
Third Chapter *Evolution*	α = 0,889	α = 0,889

The Cronbach's coefficient is quite different regarding the second chapter while including or replacing the missing values. This could be explained by the fact that from the 55 questionnaires completed only 16 participants were relevant to this section because they had an interpreter in the session. Thus, the system considered the other 39 participants as missing values.

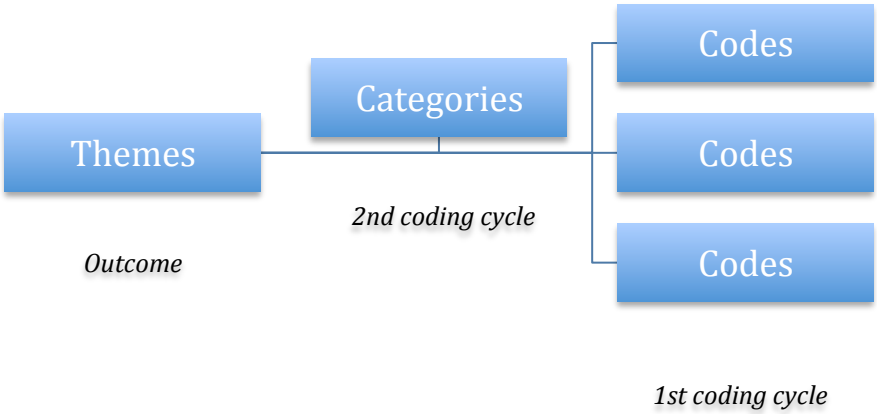
5.1.2 Qualitative Method

The content of the 20 interviews was explored through a *thematic analysis*, which is as a flexible and useful method for qualitative research "within and beyond psychology" (Braun & Clarke, 2006, p. 77). The *thematic analysis* is a method of investigation that has become very popular in the social sciences because it facilitates the exploration of meaning systems through the eyes of the other. Different disciplines have approached the topic of migration through this technique since it allows capturing the complexity of the immigrant experiences including the motivation to migrate. For instance, Eliott (1998) used this method to understand the moving experiences and health impact of Asian women who emigrated to Canada. Gonzalez Castro and Coe (2007) examined traditional beliefs and alcohol use of the USA-Mexico borders communities through thematic analyses within an integrative mixed-methods approach.

Regarding the procedure of this study, this researcher was first introduced to the content of the interviews through the data collection (interviews) and then through its transcription and/or review. This researcher transcribed 11 interviews and a Spanish-speaking psychology student transcribed 9. Before moving to the coding procedure, the interviews were read several times by this researcher. The first time with the purpose of getting familiar with their content and understanding the patients' statements. The second time they were read in order to link the testimony to the research questions (Santiago-Delefosse & Rouan, 2001). Through a third reading, the first coding cycle was performed using a coding filter that Saldaña (2009) calls *theming the data.* It refers to the attribution of words or short phrases (=**codes**) that interpret the sense of data. The author states that *theming* is not just labeling but linking ideas and data. The codes were determined according not only to their frequency, but also according to the their significance in regards to the research questions (Santiago-Delefosse & Rouan, 2001).

The second coding cycle was guided by a coding filter that Saldaña (2009) names *pattern code.* It refers to the grouping of codes. This coding process helped the creation of the major **categories** of this research data. The last phase was the development of **themes.** A theme is the "outcome of coding categorization and analytic reflection" (Saldaña, 2009, p. 13). It is a

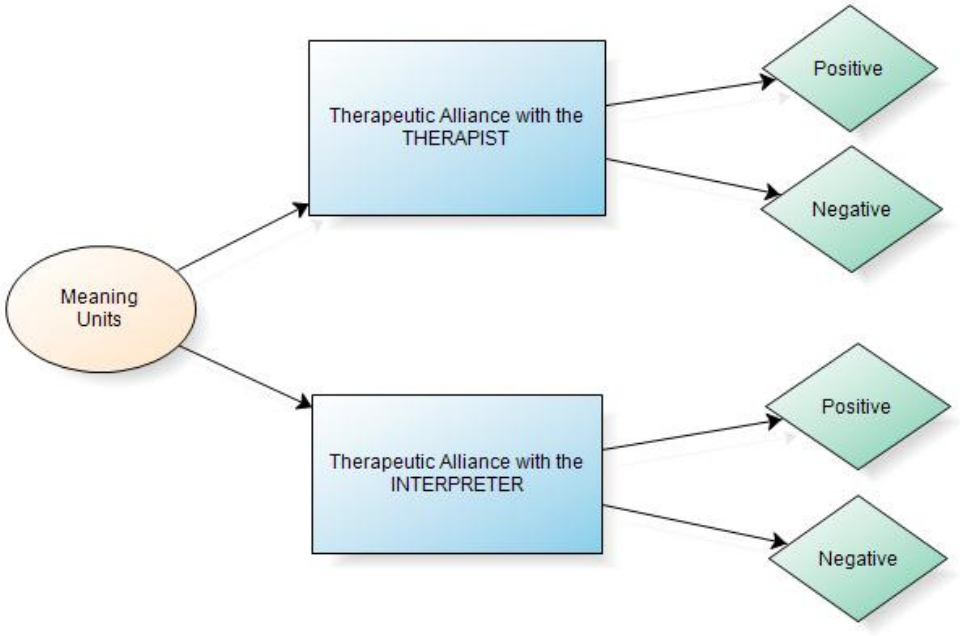
word or a phrase that symbolically represents the meaning of data in a more subtle process. The whole coding procedure is illustrated in Graphic 3.



Graphic 3. Coding procedure

The creation of themes was guided by an inductive method. However, some meaning units (based on the interview) were created a priori to guide the coding procedure and interpretation as show in Graphic 4.

The coding process was performed with the support of N-Vivo computer system. N-Vivo is software that helps to organize, analyze and visualize information, but does not do the coding itself. The researcher remains the main actor in the coding method, which according to Saldaña (2009) helps the testimony to stay in its context and its enunciation process.



Graphic 4. Meaning units to guide coding procedure and interpretation

In qualitative research, the verification of the categorization is sometimes suggested to be done by a third party to avoid subjectivity. However, Paillé and Mucchielli (2005) has shown that a third person (foreign to the project) experiments several obstacles in getting in contact with the content of the data and in consequence with its significance. In addition, the researcher has a "theoretical and experimental sensitivity" (Paillé & Mucchielli, 2008) linked to his training and his own research experience that allows him to perform an adequate descriptive denomination during the thematic analysis. Furthermore, in this case, the researcher had the advantage of being the interviewer and the analyst at the same time, which supports the contribution coming from emotional, proxemics, and kinesics elements (Paillé & Mucchielli, 2008) that are not visible through the transcript and that could enrich the analysis. According to Paillé and Mucchielli (2008), coding brings our subjectivity and personality; subjectivity that is more an indispensable element for the analysis of data than a barrier in research (Giammi 1996 cited by Saldaña, 2009).

5.1.2.1 Quality criteria of the qualitative evaluation phase

Today there exist several authors and publications that consider and discuss the matters of quality in the qualitative research as it has been done for decades in the quantitative paradigm. Guided by some of their validity and reliability criteria, in the following paragraphs I intend to demonstrate the quality of this project in regards to the qualitative evaluation phase:

- The research questions are clearly defined as well the origin of the study (Santiago-Delefosse, 2004).
- Results are compared through two different methods, what is known as triangulation (Golafshani, 2003; Mays & Pope, 2000; Santiago-Delefosse, 2006).
- The methodology offers a clear exposition of methods of data collection and analysis (Flick, 2007; Mays & Pope, 2000).
- This researcher challenges a reflexivity about her position in regards to the participants (e.g., language and cultural similarities and alliance during the interview process) (Flick, 2007; Mays & Pope, 2000).
- The study is relevant as results intend to increase the knowledge regarding the particularities of the therapeutic alliance with migrant patients in the health field (Flick, 2007; Mays & Pope, 2000), and consequently the treatment's outcome.
- The instrument seeks to gather an "authentic understanding of people's experiences" (Seale & Silverman, 1997, p. 380) through open-ended questions. Open-ended questions encourage a full, meaningful answer using the person's own knowledge and/or feeling.
- Data was recorded and transcript offering a high reliable record while giving this researcher the possibility to return to it at any time (Seale & Silverman, 1997).
- The research questions seem clear and precise (Flick, 2007; Seale & Silverman, 1997).
- The study's context or setting is adequately described through previous contextualization questions so the reader could relate the results to other settings. (Flick, 2007; Santiago-Delefosse, 2004; Seale & Silverman, 1997).

- The project is confined to a prior subject exploration in a preliminary study (Santiago-Delefosse, 2006).
- The sampling composition is described and justified (Flick, 2007; Santiago-Delefosse, 2004).
- The results analysis link empirical data to theoretical data (Flick, 2007; Santiago-Delefosse, 2004).

Another criteria in qualitative research is the analysis of negative cases ((Flick, 2007; Mays & Pope, 2000; Santiago-Delefosse, 2006). According to Mahoney and Goertz (2004) negative cases are those cases that are relevant and that are similar to the positive cases, but differ in the value given to the dependent variable (in this case the therapeutic alliance). Based on this definition, no negative cases can be identifiable in the qualitative evaluation of this research. The semi-structured interview seeks to determine the participants' positive and negative factors that facilitate the therapeutic alliance. However, the identification of negative factors would not classify them as negative cases.

6. Implications of the Methodology

The following paragraphs present two particularities regarding this research study's methodology. One concerns the evaluation of the therapeutic alliance from the patient's perspective, as already mentioned during this manuscript. The second refers to this researcher's cultural background, which may influence the conception, development and interpretation of this study.

6.1 The Patient's Perspective

This research focuses on obtaining the patient's point of view because different modalities of therapy used when working with migrants were not thought to be tailored to this type of population when they were created. For Good (1994), the concepts of health and illness are

inherent to the society. He believes that their meanings are constructed through testimonies (narrative practices). Based on his ideas, the migrant patients are the best source to determine how can health professionals better help them through a good therapeutic alliance.

Other reasons why this research is interested in the patient's perspective is "because therapy research has repeatedly demonstrated the importance of the patient's perspective on the alliance" (Horvath & Symonds, 1991 cited by Friedlander et al., 2006, p. 215). Indeed, therapists and patients often appear to disagree on the perception of the therapeutic alliance's nature and strength (Bedi et al., 2005; Boss-Prieto et al., 2010; Kramer, de Roten, Beretta, Michel, & Despland, 2008). "Theoretician defined alliance variables are not equally relevant for the patients" (Bachelor, 1995, p. 323). Moreover, Bachelor (1995), Bachelor & Horvath (2000), Horvath & Bedi (2002) and S. Miller (2009) revealed that patients' ratings have a higher correlation with outcome than therapists'.

Medical concepts that are closer to the patient's experiences facilitate the therapeutic alliance (Girard et al., 2006). Unfortunately, "historically, mental health discourse has relegated patients" (Duncan & Miller, 2000, p. 185) without acknowledging that they are "the source of wisdom" (Duncan & Miller, 2000, p. 170).

6.2 The Researcher's Cultural and Language Diversity

It is worth noting that this project's researcher used the support of three languages to elaborate this study: Spanish (the researcher's native language) for the construction and/or translation of the evaluation instruments (questionnaire and interview), contact with the participants, and data collection; English for the literature review and writing of this project's manuscript; and French (local language) for the interviews with the therapists, the discussions with colleagues and other professionals involved in this research, the literature review, contact with the health institutions that participated in this study, and thesis' defense.

In addition, it should be noted that the researcher has two nationalities (Swiss/Colombian) with professional and life experience in both countries. While this could enrich and facilitate

the contact and understanding of the patients, this researcher's own perceptions could be a pollutant for the qualitative analyses where the subjectivity of the investigator plays a bigger role. However, as already stated by Paillé and Mucchielli (2008) subjectivity is a key element in research.

Furthermore, a question related to language diversity was brought up when choosing the nomination of the participants. As a result, the word *patient* instead of *client* was kept in the structure and development of this manuscript. This choice was guided by the context where the study was conducted, even though this document is in English and the English literature frequently gives a preference to the patient nomination.

FIFTH CHAPTER: RESULTS

1. Contextualization: Hispanic American Patients and Therapeutic Settings

Following is an overview of the Hispanic American patients and the therapeutic settings where they seek medical, psychological/psychiatric, and/or social assistance in Lausanne's Health System. Outcomes were gathered through a semi-structured interview with health professionals from each institution and private practice and are summarized in data sheets (*see Annex F*) . Other results were completed by patients' data provided during the QALM-PS.

The relationship between therapeutic alliance, health care services' request, and different migratory journeys should be understood according to its context. In this study, this context is described by the health professionals and the patients themselves.

1.1 Hispanic American Patients in the Health Institutions: Description and Clinical Vignettes

Overall, information gathered from the health professionals corresponds to data presented through the literature review when describing the Hispanic American immigrants. The majority of the patients are women from Ecuador followed by Chileans, Colombians, and Peruvians. In private practice, while there is some variability from one office to the other, Colombians are the most represented. Women who have emigrated alone mainly constitute the Hispanic American community in Switzerland. A significant percentage of patients of this origin are illegal, and several have no health insurance. They often had gone through a difficult life pathway, live in a psychosocial precarious situation, and often feel lonely. They have very poor French skills and are often isolated in their community. Women work even when being pregnant, and frequently under illegal circumstances. Some Hispanic American mothers-to-be find themselves in non-ideal conditions to live, lead a pregnancy and give birth to a child.

A significant number of Hispanic American women who have sought services in these health institutions are undergoing psychological stress. As cited in the literature review, they often have children in their country of origin, who are usually educated by their grandparents or by an uncle/aunt. Later on, when reunification is possible, quite regularly they have difficulties in restoring relationships with their children. Despite the distance, these women keep a strong bond with their families, and with their cultural backgrounds. In comparison to other cultures, Hispanic American women are active in the society and in the working world. These women " are stronger than the average"! (social worker).

The patients' demographic characteristics and their psychological health issues seem to vary between institutions of private and public utility. Patients in private practice appear to have more stability regarding their legal status, integration, and life conditions. Their main psychological reasons for requesting health services in this private setting are family, couple, and parent/child relationships. For patients in institutions of public utility, the mains reasons are frequently related to life stress due to difficult migration circumstances. Overall, the length of treatment in psychiatric/psychological interventions is approximately one year with bi-weekly sessions. In the medical domain the most prominent reasons for seeking health services are dermatological, digestive, osteoarticular difficulties and general health conditions. Pregnancy and abortion issues are also pretty common in female patients. In general, the length of treatment goes between 1 to 3 sessions. A summary of all this information, classified by institution or private practice, is illustrated on Table 5 and Table 6. It is important to highlight that some of this information may have changed from the time it was gathered until the time it is presented.

The institutions that are visited the most by the Hispanic American patients in Lausanne are *The Water Point Association – L'Association Point d'Eau*: (44% of their patients are Latin Americans) and *The Policlinic: Department of Ambulatory Care and Community Medicine – Policlinique médicale universitaire de Lausanne (PMU)* where 11% of their patients are Latin Americans.

Table 5. The Hispanic Americans Patients of the 6 Health Institutions in Lausanne

This is information was gathered from the different Institutions that collaborated with this project. Its content belongs to data from 2008-2009 except statistics. Frequently, statistics are related to the whole Latin American Community (=Hispanic Americans + Brazilians).

Institution	Appartenances Association	Policlinic (PMU)	The Children's Hospital (HEL)	Department of Gynecology-Obstetric (DGO)	Water Point	Profa Foundation
% of Hispanic American patients	In 2011: 3% including Brazilians.	In 2011: **11%** including Brazilians.	In 2011: about 1%	In 2011: about 6%.	In 2011: **44%** including Brazilians.	In 2011 : about 5 % for *Planning* including Brazilians.
Principal countries of origin (Brazil not included)	Especially Ecuador. Before lots of Colombians, but now being replaced by Argentines and Chileans.	Especially Ecuador. Followed by Chile, Colombia and Peru.	Ecuador with 48%, followed by Chile 19%, and Colombia 11%.	Especially Ecuador. Followed by Chile and Peru.	Especially Ecuador. Followed by Chile and Colombia.	Especially Ecuador. Followed by Chile and Colombia.
Mains Reasons for seeking health services	Psychological issues such as family, couple and parent-infant relational difficulties. Daily life issues that are increased by the migration process.	*Gen. Medicine*: Skin problems; difficulties with the digestive (stomach ache) and ostéo-articular (back ache) system. *Psychiatric Unit:* Not determined because very few cases.	Infants, children and adolescents' medical and chirurgical difficulties. Appointments are either planned or emergency.	*Planning:* Mainly for abortion. Otherwise, contraception. *Maternity's Policlinic:* Pregnancy's medical follow up.	Sanitary services (laundry and showers). Professional services: Mainly nursing, followed by osteopathy dental care; psychological support.	*Planning:* Contraception and medical advice (pregnancy ambivalence or sexual diseases) *Perinatology:* Pregnancy: financial aspects and stress issues
# Sessions (average)	They change depending on the reason for seeking psychological services and on the patient's availability. It could go from months to years.	*Gen. Medicine*: Only 11% need more than 3 appointments. *Psychiatric Unit:* Average of few sessions, but varies depending on the case.	In average: 1 to 2.	*Planning:* Few sessions for contraception or abortion. *Maternity's Policlinic:* For pregnancy, an appointment every 6 weeks until delivery.	They change depending on the service. E.g., For nursing, regular follow-ups.	*Planning* Approx. 3 *Perinatology:* In average: 1 to 2. Very small % needs more than 6 appoint.
Services (related to this project)	Psychological, psychotherapeutic and/or psychiatric services.	*Gen. Medicine*: Emergency room and outpatient services for general medicine. *Psychiatric Unit:* Psychological and psychiatric interventions to patients who have sought services mainly due to physical issues.	Emergency room and outpatient services for underage.	*Planning:* Contraception, post-partum, sterility, and abortion. *Maternity's Policlinic:* Gynecological and obstetrical appoints. For pregnant women.	Nursing, osteopathy, psychology, dental care, gynecology, body massages, podology.	Pregnancy, sexuality, couple relationships. Workshops on sexual health prevention. (e.g., *Migration and Intimacy Program*)
Interpreters Request	Not often for this language because these cases are usually attributed to Spanish speaking therapists. If not, a community interpreter is requested.	*Gen. Medicine*: There is no official system available. There are 6 to 8 professionals who speak Spanish. In other cases, the patient brings his own interpreter (family member or friend). *Psychiatric Unit:* One Spanish speaking professional available. If not, request of a community interpreter.	Not systemically. However, there existed a service available half a day every two weeks. If not, request of other Spanish speaking colleagues belonging to the hospital for the transmission of basic info.	A couple of Spanish speaking professionals available. If not, request of Spanish speaking colleagues belonging to the Institution. Otherwise, the patient brings his own interpreter (family member or friend).	Principally for psychological services. There are about 5 professionals who speak Spanish. In other cases, request of Spanish speaking colleagues belonging to association. Sometimes, volunteers available, or the patient brings his own interpreter (family or friend).	Few Spanish-speaking professionals available. When needed, the patient brings his own interpreter (family member or friend). Otherwise, use of visual resources to communicate. For this language, the institution in very few cases provides an interpreter.

Table 6. The Hispanic Americans Patients in the Psychotherapeutic Private Practices

This information was gathered from the 3 private practices that collaborated with this project. Its content belongs to data from 2010.

	Private Practice (Mental Health)		
	Office 1	Office 2	Office 3
% Hispanic Americans	25%	100%	2 to 3 %
Principal Countries of Origin (Brazil not included)	Colombia	Venezuela, Uruguay, Bolivia, Argentina	Colombia, Ecuador and Peru.
Mains Reasons for seeking mental health services	Family issues and abuse.	Couple issues and changes related to life cycle.	Adoption (Colombian children by Swiss families); couple issues, social integration difficulties.
# Sessions (average)	Bi-weekly sessions during one year at least.	Bi-weekly sessions during one year at least.	Varies from one case to the other. At least, one-year treatment in weekly or bi-weekly sessions.
Services	Mainly psychotherapeutic.	Psychotherapeutic	Psychotherapeutic, psychological and psychiatric
Interpreters Request	No. Therapist is Spanish speaking.	No. Therapist is Spanish speaking.	Rarely. Hispanic Americans are seen most of the time by the Spanish speaking therapist.

Since its creation in 1999, *The Water Point Association* is widely the most visited institution by the Latin and Hispanic American representing a place of privilege for this population. This is due, on the one hand, to its mission of helping people in important physical, psychological and social straits (characteristics corresponding to a large percentage of people from the Hispanic American community). On the other hand, I believe the Association's principles of listening, empathy, humanity and respect create a secure

environment for the 85% of the illegal patients that frequent their services. Similarly, the association is an enormous source of health support considering that the majority of consultants have no health insurance.

According to statistics of 2011, 83% of consultants are old patients. This reveals a long history of good relationships between *The Water Point Association* and a community of people with important life needs and limited resources. This is a proof as well of the existence of a therapeutic alliance between individuals and institutions.

Clinical Vignettes

The following four clinical vignettes were chosen among the 20 interviewed participants. The four cases correspond to women because today's Latin Americans migration stories are mainly feminine (Bodenmann et al., 2003; Sangra Bron, 2006; Valli, 2003, 2007; Wolff et al., 2005). These vignettes are intended to represent some migratory journeys, life conditions, and reasons for seeking health services of the Hispanic Americans patients. Analyses towards the exploration of the therapeutic alliance will be preformed in the *Sixth Chapter: Discussion*. Choosing among the cases was difficult, because every story illustrates something specific from what was described about the Hispanic American community in Switzerland. However, I have chosen fours cases according to an element that seems determinant in all above cited characteristics: the legal status. The legal status frequently determines the context in which the immigrant arrives, assimilates and integrates (if possible) the host country.

The first clinical vignette, represents the reality of the undocumented who constitute the majority of the Hispanic Americans migrants in Switzerland (according to literature and interview resources); the second one, embodies a life story of the illegally arrived Hispanic Americans who have experienced very similar conditions to the first group, but have been able to achieve a legal status; the third one, exemplifies the life story of undocumented who request residence permits; and the fourth reflects the situation of the legal Hispanic Americans. While this fourth group is the less represented among their community members in Lausanne, it was the most represented in this study. The participants' real names were changed due to

confidentiality issues. Because the purpose of the interview was mainly to explore the patient's therapeutic relationship with their therapist, some migration and health issues were not investigated unless brought up by the participant.

To start with, here is the story of Rebeca. A single mother whose illegal migrations projects were oriented towards her children well-being.

> ***First Clinical Vignette***. Rebeca is a 52 year-old Colombian woman. She has lived illegally in Switzerland for 10 years. She starts narrating her migration story by describing the reasons that brought her to this country. Rebeca was left alone by her husband with their two children while leaving in Colombia. "*He left home and we have never heard from him again*". When she realized that she could not provide her children with all their needs due to financial restrictions, she decided to move to Switzerland. She had heard that this was the country that could host her. When she reached the new land, she immediately started working to send money to her children so "*they could survive*". Her children stayed with their maternal grandmother who was caring for them. Rebeca was waiting for the children to finish secondary school and become adults (18 years-old) in order to bring them to Switzerland.
>
> Rebeca's son was the first one who arrived to his mother's host country. Very soon after, they tried to find a job activity for him, but they had no success. For this reason and with the idea of legalizing his status, he left for Spain. The family had heard that in this country they were more possibilities to obtain a residence permit. In the meantime, Rebecca's daughter joined her in Switzerland. On the contrary, her daughter was able to find an employment for two years before following her brother's path.
>
> Today, Rebeca continues living in Switzerland and her children in Spain. They see each other frequently. However, she decided to not move to Spain because she has better job opportunities in Switzerland. When asking about her projects, she states " *I have not thought much about going back to Colombia because my children are here*". Other reason for not returning to her home country is because her parents have already passed away.
>
> In regards to Rebeca's request for health services, the first time was due to medical exams that she had to follow routinely because of a cystic fibrosis. The second time was due to strong physical issues related to her menopause. Rebeca stated that she chose this particular health institution because the services are free and lots of people from the Hispanic American community were always around. She also mentioned the health professionals' warmth, their efforts to always understand her needs, and their availability. As it relates to her

relationship with her therapist, on the one hand, Rebeca values the existence of trust and respect between both of them. On the other hand, she positively highlights feeling close to her therapist, almost like "*a friend*". Rebeca appreciates the fact that the therapist goes beyond her physical illnesses to understand her overall feelings. "*I was seeing her for physical problems, but she always was interested in other of my problems…those things that we have no courage to openly talk about without prompting"*. In addition, Rebeca outlines her health improvement and that her "*problems have disappeared*".

This first clinical vignette illustrates the most frequent migration journey of illegal Hispanic American residents in Switzerland: a migration project directed towards improving the family life conditions (Bodenmann et al., 2003; Carbajal, 2004; Sangra Bron, 2006; Valli, 2003). In this case, a journey undertaken by a single mother who was abandoned by the father of her children, leaving all child rearing and financial responsibilities under her care. Thanks to a strong family support system well-known in Hispanic Americans, this woman was able to leave her children with her own mother until re-uniting was possible (La Roche, 2002; Valli, 2003, 2007). For this Hispanic American female, "the legality in the illegality" (Carbajal, 2001) seems to have facilitated some sort of integration to Switzerland after residing undocumented 10 years. For her children, Spain seems to have been the entrance door to integrate their new home continent, through employment and legalization opportunities (Uribe, 2012). In regards to her health state, it seems it was influenced by a specific physical pathology and normal women's developmental changes. The contact with the health institution and her therapist seems to have been a support mechanism that transcends her physical needs.

Now, let' see the "love story" of Juana for whom initial painful migration movements had a happy end while making it possible to transform precariousness into stability.

Second clinical vignette. Juana, 40 years-old, is originally from Ecuador. She left her home country in 1997 and entered Switzerland with a migrant network service that helped undocumented people reach the European dreamland. She decided to be part of this adventure with the goal of improving the financial stability of her family. She was a single mother and had no other economic support. She had accidentally become pregnant and her partner left her when he found out. "*Like all macho Latino men, he avoided his responsibilities*". Juana's father savings were used to buy the plane ticket. Thanks to her cousin, who was already residing in Switzerland, three days after her arrival Juana found a job as a "maid of company". She was taking care of an elderly couple. She felt lucky because she was able to keep this job for 6 years

and did not have to go through precarious conditions as she has "*seen others*".

Juana describes the separation from her daughter (when she left Ecuador) as one of the most "*terrible*" experiences in her life. Her daughter was only 4 years old at that moment. Fortunately, only 6 months had passed by in Switzerland when she met her current husband who brought plenty of joy to her life. Thanks to him, she was able to set up a family, bring her daughter from Ecuador and have a second child, while feeling loved and respected. In addition, Juana's husband help her bring to Switzerland her brother and sister. Jauna keeps a bond with her home country and visits her parents approximately every two years. Within Juana's migration projects, the permanent establishment in Switzerland seems the first option. However, she has considered going to her husbands' home country (Iraq) following his idea of opening a family business.

Juana sought emergency medical services due to a serious infection that had expanded from her throat through her ears and nose. "*I was self-medicating until the point that I told myself that I needed to see a doctor*". From this one encounter, Juana states that she appreciated the health professional's kindness because "*there are doctors who are so rough*". Juana felt emotionally touched by the therapist's real and profound concern for her case. The therapist's interest made Juana felt important, until the point that "*her pain decreased a little bit*". When asking Juana for her criteria to define a good relationship with a therapist, she brought up respect, gentleness, and a non-judgmental attitude. She states that this is important in creating trust, especially because "*they are several people who are afraid of going to the doctor*". Juana described the doctor's going above and beyond as another positive aspect in this medical encounter. She described being happily surprised by the fact that instead of delegating a nurse to do an exam, the physician took the time to do it herself. When asking Juana about negative aspects in the relationship with her therapist, she could not find any, but referred to a case where her sister had a bad experience due to race discrimination or "*because she had no legal papers*".

This is the story as well of a single mother striving to improve the economic stability of her family in a foreign land, but with a difference: her undocumented identity could be transformed in legal. This woman, an Ecuadorian as the majority of Hispanic American residents in Switzerland, had a migration journey first supported by an illegal network and then consolidated by a love story. Story that in many cases makes part of single woman migration projects (Valli, 2007). While a quite rapid success was achieved in her host country due to a stable relationship and employment, the suffering of the separation from her little daughter was almost as traumatic as her previous unwanted pregnancy. The success in her new

country, in a way that many others do not often accomplish, protected her from additional ordeals and difficulties. Regarding the health issues of this Hispanic American migrant, self-medication (Besson, Desmeules, Wolff, & Gaspoz, 2007) constituted one of her healing practices. This is very common in this type of population. This patient describes her one time encounter with her therapist as an emotionally positive experience that helped her improve her physical health.

Now, let's continue with Rosa's story: a migration project that involved an entire family as a gesture of "generational altruism" (Gomez, 2005) from the parents.

> ***Third clinical vignette.*** Rosa, 42 years-old, is originally from Chile. She, her husband, and their two children arrived in Switzerland in 2001. Rosa and her husband were motivated to undertake their migration journey by a cousin who offered them job opportunities in the European land. However, they mainly wanted to offer a better education for their children. "*We thought the most important thing was for them to have a good education so they would not have to live what we lived*". According to Rosa's testimonies, the family was very naïve concerning the knowledge about legal documentation. At that time, Chileans did not need a visa to enter the country. However, the family did not differentiate between traveling and residing in Switzerland, and therefore became illegal after a few months. The family has been under a "permit request status" for 4 years, and their situation is still unclear, which makes it difficult for them to build future projects. Rosa states, "*we will go back to our country*" if their permit is refused because "*it is difficult to be without a permit*".
>
> Rosa requested psychological services while being referred by the Psychology Center where her daughter was treated for sexual abuse in the past. At the beginning, Rosa described the contact with the therapist as difficult. It was the first time she was seeing a mental health provider. "*I felt she did not understand me*", even if Rosa appeared to have some French language skills. After the first session a professional interpreter joined, which Rosa considered quite valuable. "*Clearly, it helped me a lot to have her there*". Rosa feels that the interpreter was especially useful in transmitting her emotions, and above all, in making her feel secure. She felt safe when realizing that what she wanted to say was accurately conveyed to the therapist. Rosa said also appreciated the interpreter's kindness and the tranquility she inspired. As a patient she felt listened and understood by the therapist since they became a triad. She even felt she could be more authentic. Thanks to the interpreter and how she helped, she had the feeling that "*the habits or cultures of each other*" did not stop the therapist from helping her. When asking Rosa about specificities of her relationship with the therapist, she cited how useful therapy has been for her. In addition, she evoked a situation in which the therapist helped her

creating a communication bridge with her husband during a session. "*She was able to tell my husband many things that she knew I wanted to tell him but could not*". Regarding the negative aspects, Rosa brought up her therapist's initial feelings of mistrust regarding her migration processes.

Here is the example of a whole Hispanic-American family whose migration project seems to have been built on an utopic reality. While entering Switzerland took place under good conditions, the difficulties to legally integrate the country appeared to have prevented them from obtaining stability in several spheres (Carbajal, 2004). Unlike the other clinical vignettes, this case exemplifies a triadic setting. Psychological services are described as a good support for almost the entire family. This is especially important for a family that had no previous experience in requesting mental health services. The psychological sessions became more significant and reassuring since the presence of an interpreter was guarantee.

Finally, this is the life reality of an opposite case: legal migration. This example confirms how migration movements weaken people or promote vulnerability despite the legal status.

Fourth clinical vignette. Camila is a 42 year-old Colombian woman. She arrived to Switzerland in 2008 with her Swiss husband. Due to her husband's working activities, they had previously lived in Paris and Germany. When speaking about her migration projects, she stated that they were principally shaped by her wish of funding a family. "*My first project was to have a family, that's why I followed my husband where he was, where he had his job*". Now that their wishes have come true thanks to the arrival of a daughter and a son, Camila focuses on her professional projects. In regards to the future, she says "*I dream of returning to Colombia to die there. In any case I know I do not want to die here, in the last days of my life, I don't want to be here or in any other country. I want, like the salmon, to go back (laughs) .... that, I have it very clear, but for now and hopefully for a long time I hope we will be here*".

Camila requested psychological services in a private practice office due to couple relationship issues aggravated by migration dynamics. She had first chosen this particular therapist because she was a Hispanic American woman as well. "*For me it was important to do it in Spanish because I could express everything*". In addition, Camila thought that a female from her same home continent could better understand her. "*My therapy would not have been the same if I had seen a European psychologist. I believe she understood me*". As a patient, Camila appreciated the respect and listening provided by her therapist. This in addition to the insight that she brought her to during the sessions, which was accompanied by positive changes. Camila

> stated that the therapist always kept a distance with her. While this was initially disappointing for her as a patient, at the end she realized it was the best for her own personal work. "*It is better that she does not become my friend, because if she does I would lose her as a therapist*". When evoking negative aspects of their therapeutic relationship, Camila spoke about some sessions in which she felt she had lots of expectations that were not fulfill. At times she felt like dropping off when no observable progress was achieved.

In contrast to previous cases, this migration journey was undertaken in legal circumstances. As for many documented Hispanic American women, it was driven by the desire of following a husband and a family project (Riaño, 2003). In this case, secondary projects are orientated on the professional sphere as part of her personal development in her new home country. This woman clearly represents the theory of the "Salmon Bias" (Turra & Elo, 2008) when evocating her desire to go back to Colombia to die. In regards to the health aspect, couple relationship difficulties intensified by migration changes were identified as her cause for requesting psychological services. These difficulties are frequently the reasons for consultation among legal documented Hispanic Americans that visit private practice offices. The therapeutic relationship of this patient with her therapist was created throughout several sessions that stimulated the patient's own insight.

1.2 Health Professionals' Perception of the Hispanic American Patients

Health professionals in Lausanne strongly agree that Hispanic Americans are resilient to life struggles: "they are always fighting" to overcome difficulties, "they get by very well" (social worker). Hispanic American patients have "an inside force that helps them progress with minimum support" (nurse). "They have an admirable force of combativeness, don't like to feel as victims and are very creative in finding solutions to their problems" (psychiatrist). Moreover, this community is perceived as being autonomous and intelligent, with a capacity of adaptation to their surroundings. Therapists believe that despite the numerous challenges with which they are confronted, they have the tendency to keep a good sense of humor and the joy of life. However, "they suffer despite their cheerful character" (social worker). A trait of

this community is the spirituality and the religion, which occupy a special place in their lives, and strongly influences their force to confront problems and to believe in the future.

Therapists think that Hispanic Americans rely more on emotions than other cultures, from the feeling to the expression. Professional encounters are "more animated in smiles and in tears" (generalist physician). Indeed, there is an inclination to establish physical contact with the therapists. A particularity described by some of the therapists about this community is the strong importance given to the physical aspect, especially by Hispanic American women. They like to present themselves well dressed and groomed. The importance given to the feeling of being attractive is highly taken into account. This point should be put forth when identifying dermatological problems as one of the most important reasons for seeking medical services.

The Hispanic American patients' choice when seeking health services in Switzerland is principally determined by word of mouth. They follow what others tell them could be helpful; they discover through others' experiences. For new Hispanic American immigrants, it is useful to learn and follow steps from their compatriots, and for the ones already installed in the foreign country, the diffusion of information and sharing with others is a proof of community support. As previously cited by references and as perceived by the health professionals, this community's strength is the solidarity towards its members. They are not only family-oriented, but also group-oriented. However, that solidarity is replaced at times by "a feeling of competition" (nurse) when confronted with job or residence search.

In regards to health services, while this community seeks medical services when having the means, the psychological problems seem to continue being a taboo at certain social levels. While psychology is a profession culturally well recognized and generally available (with the exception of some underserved urban or rural population), psychological issues are often associated to weaknesses and shame. This seems to be a reason for not requesting this service as a first aid. On the contrary, medical services are more frequently demanded. In addition, Hispanic Americans health practices made them seek health services when in an emergency and for tangible reasons.

In reference to the Hispanic Americans' behavior or attitude while being in session, the health professionals consider them as active patients, as people who "have a strong desire to understand and to know" (sexual and reproductive health advisor). Therapists describe them as respectful, discreet, correct, informal, and grateful people. They believe patients from this origin easily establish an affective relationship when overcoming the mistrust that often accompanies the first encounters. Once they feel they are in a safe place that they trust, they easily open to the other. The feeling of being secure is described as a profound need for non-documented immigrants. Later on, the health professional becomes an ally; he becomes a great support in their migration journey, someone they can trust. In consequence, small presents (e.g., souvenirs from their country) and expression of thankfulness become an important way to recognize the help provided by the therapists. Hispanic Americans are described as patients who are very respectful of the health professionals, especially of the medical staff. Despite this, Hispanic Americans tend to prescribe for others and to exchange medication without the doctor's consent. Regarding the psychological/psychiatric consultation, some professionals perceive them as patients who have the tendency to be more passive in therapy than others. While they wait to receive concrete solutions to their problems, they do not show an interest for the analytic understanding of their difficulties.

From the health professionals' point of view, Hispanic American patients are more compliant when they can express themselves in their mother tongue and when things are presented in a clear manner. Therapists agree that a trusting environment is the key for their participation in their own treatment/intervention. "The more stable the structure and their social and economic environment, the more compliant they will be" (general physician). Moreover, other aspects that seem to facilitate the compliance of this community are a) the feeling of being valued, b) the power to choose what relates to their health, such as choosing their contraceptive method, and c) a warm and respectful relationship.

Health professionals consider that one of the challenges with patients of this community is the non-compliance with their appointments, especially when their social and economic environment is not stable (information that coincides with literature references). An obstacle

to treat Hispanic American patients is their "failure to keep appointments, sometimes without previous cancellation, often times due to work responsibilities". Also they have difficulties in "being consistent when following their treatments" (nurse). In addition, other medical difficulties relate to the fact that Hispanic American have "a tendency to trivialize drugs", e.g., to devalue the importance of a prescription, or to believe that a medication is useful for everything (testimony of a physician).

When citing other obstacles, health professionals highlighted the patients' legal and socio-economic difficulties that sometimes either prevent them from treatment or produce abrupt drop-offs. While nowadays illegal immigrants have the right to a health insurance, in practice it continues to be restricted. Furthermore, the insurance's monthly payments are disproportionate to Hispanic Americans' average salaries. In addition, some institutions do not accept patients without a health insurance.

Some health professionals, who do not speak Spanish, find the communication with the patient as a main obstacle because in several cases it is not possible to request an interpreter. These statements corroborated once again the existence of language barriers in health care in Switzerland for more than a decade.

1.3 Greeting and Communicating Strategies with the Hispanic American Patients

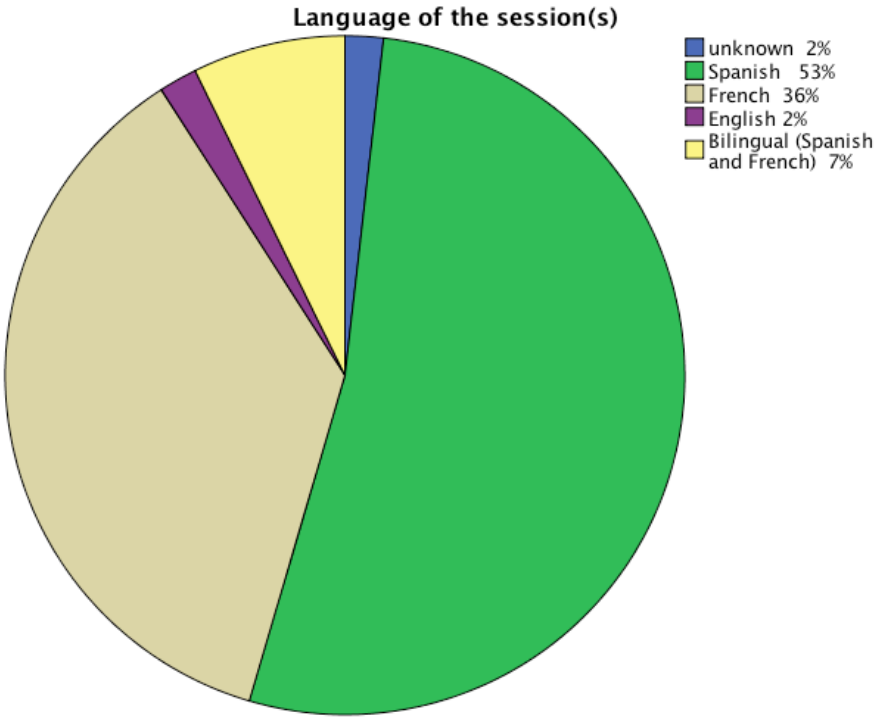
The following results describe how the Hispanic American patients are greeted when requesting health services in Lausanne's Health system in terms of communication. According to the therapists, professional interpreters (*community interpreters*) are not really requested in therapeutic settings with Hispanic American patients as illustrated in the last section of Table 5. This information validates data provided by the patients. Private practices very often count with Spanish speaking therapists making unnecessary or less relevant the presence of an interpreter (last section Table 6).

In relation to the information gathered from the patients during the questionnaire, sessions with Hispanic Americans in the health institutions of Lausanne are mainly conducted without

an interpreter, or in a dyadic setting (for 72% of the participants in this study). These take place mostly in Spanish and French and sometimes in English. In most cases, sessions are in Spanish (53%) whether the therapist speaks, or is fluent or not on this language (see Graphic 5).

Few institutions have the structure and the financial ability to afford costs of a professional interpreter. When it exists, it seems to be a privilege of psychological/psychiatric services. Thus, some patients are not fortunate enough to have the presence of an interpreter when receiving psychological support.

The absence of an interpreter is often justified (on behalf of the therapists, but also on behalf of the patients) by the excuse of the similarity between the two languages of Latin roots (Spanish / French), which hypothetically allows a mutual understanding.



Graphic 5. Language of the session(s)

In the cases in which 53% of the sessions are conducted in Spanish, this happens thanks to the important number of Spanish speaking therapists available in Lausanne's region. Nevertheless, it is not always possible to find a health professional with the necessary language skills to lead an entire session and/or treatment in this foreign language while keeping clarity, comprehension, and effectiveness. In this study, only 33% of the therapists were Spanish-speaking (22% of Hispanic American origin and 11% of other origins), according to the patients. This means that 20% of the sessions are conducted with no common language!

Regarding the **triadic setting** (28% of the cases), languages barriers in most cases are resolved by seeking the help of a non-professional interpreter. In reference to Hsieh's classification, results show that ***13%*** of all participants had an ***untrained interpreter,*** for example a bilingual support staff from the same institution that happens to be available, and will most likely do a literal translation (e.g., secretary, receptionist, cleaning lady, etc.). In ***7%*** of the cases a ***chance interpreter*** (family member or friend) served as a communication bridge in health sessions. The ***professional interpreter*** was present in ***7%*** of the cases (See Table 7).

These findings corroborate studies in Switzerland from the last decade (Slobin, 1996) showing that no important progress has been made in the country concerning the culture of interpretation and the use of professional interpreters (*community interpreters*) in health services provided to migrant patients.

Other communication strategies used by health professionals when experiencing language barriers imply the use of non-direct verbal language: drawings, mimics, and translation via Internet during the sessions.

Table 7. Therapeutic Settings evaluated with the QALM-PS

Interpreter in the session(s)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	**Dyad**: No Interpreter	39	70,9	72,2%	72,2
	Triads:				
	Chance Interpreter	4	7,3	7,4%	79,6
	Professional Interpreter	4	7,3	7,4%	87,0
	Untrained Interpreter	7	12,7	13%	100,0
	Total	54	98,2	100%	
Missing	99	1	1,8		
Total		55	100,0		

In conclusion, results from this study show that, with the Hispanic American community, there are more tendencies to meet patients in a *dyadic* than a *triadic therapeutic setting*. This means that few cases count with the presence of an interpreter even if communication issues exist with this population as stated by the literature, the therapists, and the patients. In the less represented *triadic settings*, the responsibility of communicating with the health professional has indirectly been attributed to the patient who brings a close friend or relative to play the role of the interpreter. Bischoff and Hudelson (2009) state that a family interpreter should be included in the session as an advocate for the patient, but not as an interpreter because he is not capable of ensuring accurate information transfer.

1.4 Health Professional's perception of the Dyadic and Triadic Work in Therapy and the Influence of an Interpreter

Working with or without an interpreter is perceived as a totally different task and therapists have diverse feelings about it. On the one hand, for few health professionals, especially in the mental health domain, the presence of an interpreter is perceived as an

essential element that allows accessing a series of meanings. The influence of the interpreter is viewed as positive by some therapists because it facilitates communication between different languages while bringing cultural elements. At the same time, it represents a company for the patient in his therapeutic path. It is believed that the experience and the habit of working with a *community interpreter* create an equal comfort in both settings: *dyadic and triadic*.

On the other hand, a high number of therapists view the presence of an interpreter as disturbing and prefer a dyadic encounter. They state that it is "difficult to circulate emotions" with three participants and prefer a two-way communication pattern. They believe the interpreter is incapable of transmitting simultaneously the verbal and the non-verbal content. In addition, they feel that the triadic work is "tiring", whereas the quality of the information becomes lost. Therapists stated that the triadic work is not intuitive and that they have the feeling that they are not sufficiently well trained for it. Working with an interpreter is more time consuming for them and requires a higher degree of trust. For some health professionals, the presence of an interpreter is considered a additional difficulty.

However, when the interpreter is a *community interpreter,* his presence is considered more interesting because it facilitates the cultural exchanges and goes beyond a word translation. Some therapists think that when the language facilitator is a *chance or trained interpreter,* his presence makes the session's dynamics more difficult because he disturbs the communication and its content, while adding more subjectivity to the encounter. The presence of a non-professional interpreter could be experienced by the health professionals as a threat for the therapy due to the loss of confidentiality and the creation of nuances.

Regarding the bond with the interpreter, someone's view describes it as complex, because sometimes it is difficult to develop a good bond between all the three dyads (therapist-interpreter, therapist-patient, interpreter-patient). Another one with more experience in working with professional interpreters describes this connection as easy, interesting, likeable and important. Therapists think that a triadic bond is positive when the relationship between the three participants is considered "good". The relationship with the interpreter is also perceived as a collaboration with another professional to better understand the patient. This

becomes at the same time an opportunity for the therapist's cultural learning. Some health professionals believe that the bond with the interpreter depends on his type. Thus, in any case it needs to be "woven", and for this training is required.

2. Objective: Study of the Therapeutic Alliance

The following results stem from the objective of this research project: the evaluation of the *Therapeutic alliance* between different health professionals (therapists) and Hispanic American patients in a cross-cultural health care context. Findings were gathered through the Therapeutic Alliance Questionnaire for Migrants – Health Professionals' version (QALM-PS) and a semi-structured interview.

Quantitative phase: In total, 55 questionnaires of the Therapeutic Alliance for Migrants – Health Professionals' version (QALM-PS) that corresponded to the inclusion criteria were completed and returned. The response rate of the QALM-PS was 30%.

Qualitative phase: From the 55 patients who completed the QALM-PS, 20 of them agreed to participate in the sequential part of this study. A semi-structured interview was conducted with each of these 20 patients during face-to-face meetings. The response rate was 37%, lower than the 30 interviews (=67%) that were expected.

In this study, 70% of the participants requested medical or social assistance and 30% demanded psychiatric/psychological assistance. However, it's worth noting that an important amount of patients received psychological support while getting their medical treatment as illustrated along this manuscript.

3. Research Questions

Results that followed are classified and presented according to each research question.

3.1 Strength of the Therapeutic Alliance

The strength of the therapeutic alliance between the therapist and the patient in a *dyadic* and *triadic setting* was measured with the help of the quantitative instrument: the QALM-PS.

According to the non-parametric test of Mann-Whitney U, the distribution of the Therapist's Total Score Therapeutic Alliance is the same across categories of a *triadic and dyadic setting*. The strength of the therapeutic alliance in a *dyadic setting* (*Mdn* = 89.0, *IQR* = 15.0) did not significantly differ from a *triadic setting* (*Mdn* = 85.5, *IQR* = 11,75), U = 311.500, z = 0.009, p = 0.993.

This results indicate that the strength of the therapeutic alliance between the therapist and the patient is about the same in a dyadic setting (in the absence of an interpreter) than in a triadic setting (in the presence of an interpreter). In consequence, according to these results, the presence of an interpreter does not influence the strength of the alliance between the therapist and his patient, from the point of view of this last one.

The same analyses were done individually with each of the 4 a priori defined *Alliance Dimensions* (see next section), and the results didn't differ between the dyad and the triad.

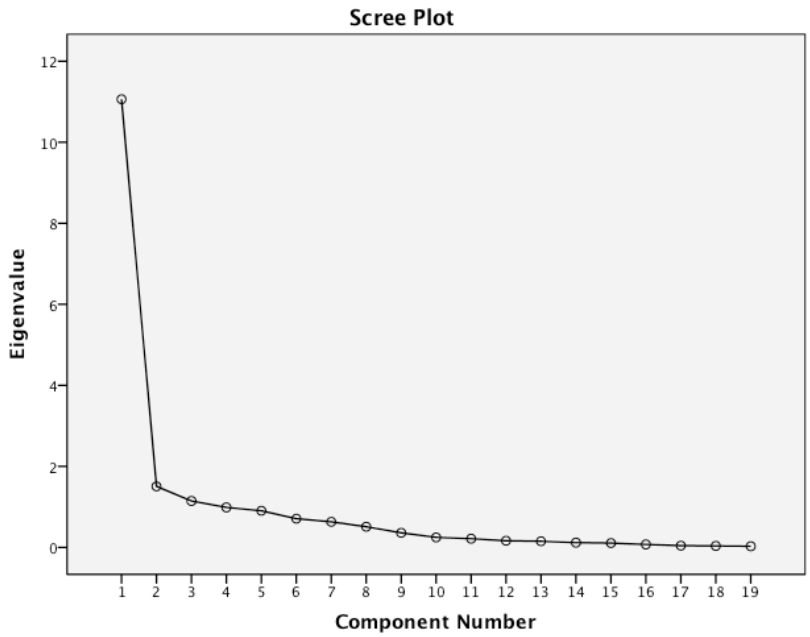
3.2 Factors that Influence The Patient's Therapeutic Alliance with the Therapist and the Interpreter

Both instruments: quantitative (questionnaire) and qualitative (semi-structured interview) searched to identify the factors that influence the patient's therapeutic alliance with the therapist and the interpreter.

3.2.1 Quantitative results

First analyses were focused on measuring the possible existence of a subjacent structure in the questionnaire that would allow the identification of factors that compose the therapeutic alliance itself.

Secondly, 4 dimensions were considered to be part of the questionnaire: *Nurturing, Relationship, Security and Assistance* (Boss-Prieto et al., 2010). A Principal Component Analysis indicates that 58% of the variance is explained by the first factor. This suggests keeping only one dimension according to Cattell's criteria (Cattell, 1966) and as illustrated by The Scree Plot (See Graphic 6) .



Graphic 6. Principal Component Analyses

Furthermore, a Component Matrix (Table 8) illustrates that the majority of the items are concentrated in the same first factor, suggesting again that there exists only one dimension in the structure of the questionnaire. In the majority of the items, in the first component, there is a value superior to 0.6 that implies a strong correlation between the 19 questions of the questionnaire, and a low variance between them.

Table 8. Component Matrix

Component Matrix[a]

	Component		
	1	2	3
I1	,809	,173	-,072
I2	,178	,752	,184
I3	,738	-,359	,301
I4	,854	,019	,155
I5	,652	,447	,249
I6	,672	,091	-,605
I7	,876	-,043	-,304
I8	,935	,026	,097
I9	,728	,233	-,276
I10	,929	-,077	-,051
I11	,836	-,022	-,064
I12	,848	-,297	-,020
I13	,761	-,394	-,150
I14	,925	,023	-,178
I15	,189	,015	,301
I16	,779	-,167	,352
I17	,746	-,211	,283
I18	,698	,432	,009
I19	,809	,087	,173

Extraction Method: Principal Component Analysis. 3 components extracted

This means that all the dimensions determined a priori are strongly related. The low variance between them makes it impossible to obtain any differences, and suggests retaining only one scale (See Table 9). Therefore, no alliance dimensions exist in the structure of this questionnaire.

In a final effort to find a subjacent structure in the questionnaire, a supplementary principal component analysis with rotation method *Varimax* and *Oblimin* (with 3, 4, and 5 factors) was performed. So, neither subjacent structure clearly emerged from the instrument that could suggest the existence of dimensions. However, while my objective was to find the a

priori therapeutic alliance dimensions, from a statistical perspective the unidimensional questionnaires have better psychometric properties in terms of reliability and validity (Revelle & Zinbarg, 2009).

Table 9. Matrix of Correlations (a priori dimensions of the QALM-PS)

Correlations

			Assistance Dimension	Nurturing Dimension	Security Dimension	Relationship Dimension
Spearman's rho	Assistance Dimension	Correlation Coefficient	1,000	,782**	,704**	,730**
		Sig. (2-tailed)	.	,000	,000	,000
		N	55	51	54	50
	Nurturing Dimension	Correlation Coefficient	,782**	1,000	,707**	,705**
		Sig. (2-tailed)	,000	.	,000	,000
		N	51	51	50	48
	Security Dimension	Correlation Coefficient	,704**	,707**	1,000	,753**
		Sig. (2-tailed)	,000	,000	.	,000
		N	54	50	54	50
	Relationship Dimension	Correlation Coefficient	,730**	,705**	,753**	1,000
		Sig. (2-tailed)	,000	,000	,000	.
		N	50	48	50	50

**. Correlation is significant at the 0.01 level (2-tailed).

In conclusion, the QALM-PS did not allow the differentiation of facets. In consequence, this quantitative process cannot determine the dimensions or the factors that most influence the therapeutic alliance, but only measure the strength of the therapeutic alliance.

3.2.2 Qualitative results

The 4 pre-existent dimensions (*Nurturing, Safety, Relationship, and Assistance*) were identified during the qualitative analyses of this research. The dimension *Nurturing* was recalled in the present study under the themes ***Human Values and Qualities and Emotional Bond,*** which represent the most frequent themes that promote the therapeutic alliance. ***Assistance*** emerged again as its own theme with an important frequency, and *Safety* was also identified under the theme ***Emotional Bond***. *Relationship* is evoked by the theme ***Reciprocity in the Relationship,*** though it had a lower frequency. Overall, all a priori dimensions emerged again during this study's phase showing their significance in the therapeutic alliance in cross-cultural health care practice. In addition, through the emergence of themes[18], other specific factors were identified that influence the therapeutic alliance in a cross-cultural and bilingual setting. Approximately 80% of the responses were retained for the analyses according to their frequency. The frequency was determined by the sum of frequent sources and/or frequent references in the coding process. The reason for according frequencies (quantitative figures) to the qualitative results will be justified in the *Sixth Chapter: Discussion*.

In the following paragraphs, I will provide a detailed description of the themes and factors that positively and negatively influence the therapeutic alliance (TA) with the therapist and the interpreter, from the patient's point of view. Table 10 illustrates the most frequent ones. The highlighted themes in gray show the contrast between opposites.

[18] In terms of this research, the word theme recalls a dimension. A theme gives access to the factors referred to in the research questions.

Table 10. Factors that positively and negatively influence the therapeutic alliance in a cross-cultural context

	TA Positive Factors	TA Negative Factors
Therapist	• Hospitality and Warmth (13%) • Human Values and Qualities (13%) • Emotional Bond (13%) • Assistance (11%) • Above and Beyond Professional Duties (10%) • Health Improvement and Change (7%) • Equal Positions (7%) • Good Quality of Communication (6%)	• Unequal Positions (24%) • Poor Quality of Communication (13%) • Lack of Dynamism in the Therapy's Methods (12%) • Disinterest in the Patient's Well-Being (11%) • Lack of Emotional Bond (10%) • Lack of Recognition of the « Whole Person » (8%)
Interpreter	• Assistance (31%) • Above and Beyond Professional Duties (16%) • Good Quality of Communication (15%) • Human Values and Qualities (10%) • Hospitality and Warmth (7%)	• Lack of Professional Ethics (2%)

3.2.3 Positive Alliance

Overall, regarding the positive therapeutic alliance with the therapist, 15 themes emerged as the result of the coding process (Codes ➔ Categories ➔ Themes) as explained in the *Fourth Chapter: Methodology, 3.2 Qualitative approach*. In regards to the positive alliance with the interpreter, 9 themes appeared. Interestingly, these 9 themes that describe the positive alliance between the patient and the interpreter, make up part of the positive alliance between the patient and the therapist as well. This means that the factors that benefit the therapeutic alliance with the interpreter are equally important in the relationship with the therapist. However, the therapist is the main guide in the mental health encounter towards the well-being

of the patient, which implies more complexity in his work. Subsequently, this involves the existence of supplementary factors, which are not necessary present with the interpreter.

3.2.3.1 Positive Alliance with The Therapist

Hospitality and Warmth, Human Values and Qualities, and Emotional Bond were the most frequent themes that promote the therapeutic alliance with the therapist. ***Hospitality and Warmth (***with a frequency of ***13%***), refer to a welcoming reception of the patient. It involves a positive attitude of the health professional: kindness, gentleness and the creation of a space that allows the sharing of experiences. To enhance understanding of the results, testimonies from the participants illustrate each theme [19]:

> *"Maybe her…kindness….because there are therapists that, honestly do not seem… they are so rough…do you understand me?" (Ecuadorian, woman, 40 years old)*

> *"I told him, during my first appointment I told him what I HAD lived and everything I have KEPT inside". (Ecuadorian, woman, 33 years old)*

While ***Human Values and Qualities (13%)*** evoke goodness, understanding, listening, patience, respect and sensitivity, ***Emotional Bond*** with ***13%*** also refers to trust, previous knowledge of each other, empathy, security, and tranquility.

> *"I feel that she listens to me, that she respects me…that I am not just another case during her day!" (Chilean, woman, 33 years old)*

[19] The form of some transcribed text has been revised, but its sense has been kept intact. These testimonies, originally in Spanish, are TOA.

" In that moment, I felt secured, because sometimes you feel like anxious, do not you?" (Ecuadorian, woman, 33 years old).

The other most frequent themes that influence the therapeutic alliance in a positive manner are ***Assistance (11%), Above and Beyond Professional Duties (10%), Health Improvement and Change (7%), Equal positions (7%) and Good Quality of Communication (6%)*** in the professional setting. ***Assistance*** refers to the patient's sense of being helped and supported by the therapist.

"He told me: « I am here to help you. Tell me everything you want and feel »… "(Ecuadorian, woman, 33 years old)

Above and Beyond Professional Duties means going beyond the professional duties in order to help the patient; doing more than what the professional responsibilities prescribe. It is characterized, on the one hand, by the health professional's additional efforts (e.g., Spanish learning efforts, helping efforts), and, on the other hand, by the professional's close contact with the patient, and his interest and concern for him.

"I asked him, like this, if he could come to my home. He told me that he could come with no problem. And he will come!" (Guatemalan, man, 53 years old)

Health Improvement and Change refers to the efficacy of the treatment/therapy and the progress achieved during it.

"- Interviewer: So, you were telling me that one of your criteria to have a good relationship with your therapist was honesty. What else could you think about?

- Patient: The facts.

- Interviewer: Could you give an example of facts in this therapeutic relationship?

-Patient: ... from where I was to how I have been progressing". (Guatemalan, man, 53 years old)

Equal positions shed light on reaching equality between the patient and the therapist through symmetry, cultural and linguistic similarities, mutual sharing of knowledge, the patient's control over the therapy, and the therapist's self-disclosure.

"When I had the problem with my sister and my daughter, she talked to me about an experience that she had with her son..." (Ecuadorian, woman, 47 years old)

Finally, ***Good Quality of Communication*** suggests clarity in the communication, the presence of an interpreter, and the communication bridge that the therapist can create between the patient and his surrounding world.

" She established the contact herself and referred my case. She called herself and took an appointment for me". (Ecuadorian, woman, 37 years old)

Table 11 shows the most frequent themes with their respective therapist's positive factors, and patients' testimonies. *Annex G* provides the complete results of the coding process regarding the positive alliance with the therapist.

Table 11. Factors that **positively** influence the patient's therapeutic alliance with the **therapist** in a cross-cultural context

	THEMES	FACTORS	INTERVIEW EXTRACTS
THERAPEUTIC ALLIANCE POSITIVE FACTORS (THERAPIST)	**Hospitality and Warmth**	❖ **Positive attitude** ❖ Kindness and gentleness ❖ Welcomed reception ❖ **Warmth** ❖ Space to share experiences	❖ "Even if he does not speak the language, but to see a more positive attitude towards one". ❖ "That's how I found a good professional and a human, a good man".
	Human Values and Qualities	❖ Goodness ❖ **Understanding** ❖ Listening ❖ Patience ❖ **Respect** ❖ **Sensitivity**	❖ "… because I feel understood, fully understood". ❖ "Well, above all to have respect towards one". ❖ "He is aware of all of us, all who are here as immigrants, and as foreigners".
	Emotional Bond	❖ **Trust** ❖ Previous knowledge of each other ❖ **Empathy** ❖ Security ❖ **Tranquility**	❖ "I felt that I could trust and have confidence on her". ❖ "An empathy, a…a feeling, how to say? A current that passes…". ❖ "I always leave, leave with tranquility".
	Assistance	❖ **Support** ❖ Team assistance ❖ **Help**	❖ "Here they call it a crutch, and we call it a support, a moral, that, that… that shines". ❖ "…to give your hand as a person or as a professional to whom needs it".

	THEMES	FACTORS	INTERVIEW EXTRACTS
THERAPEUTIC ALLIANCE POSITIVE FACTORS (THERAPIST)	**Above and Beyond the Professional Duties**	❖ **Close contact** ❖ **Spanish learning efforts** ❖ Helping efforts ❖ **Interest and concern**	❖ "He touched my heart. His words are for me the best medicine". ❖ "…they have made efforts to learn Spanish and now they understand better, they even know the meaning of the words". ❖ "At least, I could see that he cares, he asks me questions, and he is really concerned of how things are going".
	Health Improvement and Change	❖ Efficacy ❖ **Progress and change**	❖ "Very good! Very, very, very good. He is a person that has helped me enormously to get ahead".
	Equal Positions	❖ Self-disclosure ❖ Shared knowledge ❖ Control over the therapy ❖ **Symmetry** ❖ **Cultural similarities** ❖ **Linguistic similarities**	❖ "…that psychiatry, that psychology, that medicine need to become vulgarized. Not to become poorer in knowledge, but to get richer in vocabulary and common logic for ordinary people and for the patient". ❖ "The therapy would not have been the same if I had seen a European psychologist… I believe that she understood me." ❖ "…the fact that she spoke Spanish helped me like to get closer to her, at the expression level… and at the feeling level as well".
	Good Quality of Communication	❖ **Communication clarity** ❖ **Interpreter's presence** ❖ Communication bridge	❖ "…to have communication, this means that if I ask him something that I could have a clear answer of what I have asked". ❖ "…it is better with an interpreter because… my vocabulary is limited and I want for them to understand me correctly. I want to… because I want them to help me!".

3.2.3.2 Positive Alliance with The Interpreter

Assistance with ***31%*** is the most frequent theme that promotes the patient's therapeutic alliance with the interpreter. This theme was equally present in the relationship with the therapist, but its frequency was not as important as in this case. ***Assistance*** refers to support and help as well, which makes up part of the inherent work of the interpreter. The interpreter's presence and role are focused on providing concrete help to the patient.

> *"…thanks to the interpreter and to how she supported me, I have the feeling that traditions and cultural differences did not represent an obstacle". (Chilean, woman, 42 years old)*

Another important identified theme that positively influences the relationship with the interpreter is ***Above and Beyond Professional Duties*** with ***16%***, which was equally relevant in the positive alliance with the therapist. In this case, this means having a close contact with the patient and showing concern for him.

> *" …sometimes she has cried when listening to my stories as a Latina that she is as well." (Ecuadorian, woman, 47 years old)*

Other frequent themes were ***Good Quality of Communication (15%), and Human Values and Qualities (10%).*** The first theme implies words such as communication bridge and simultaneous translation. It is important to highlight that simultaneous translation was cited only once due to his non-commonality, and non-basic necessity. This means that what ***Good Quality of Communication*** refers the most is to the communication bridge that the interpreter provides through explanations and allowance of verbal exchanges between two different linguistic worlds.

" Very well, because she explained to me what the doctor was telling me and…what he wanted to tell me". (Colombian, woman, 31 years old)

Furthermore***, Human Values and Qualities*** refers to goodness, understanding, and patience.

" She has been very good to me". (Ecuadorian, woman, 47 years old)

Finally, the last relevant theme that promotes the therapeutic alliance between the patient and the interpreter was ***Hospitality and Warmth (7%),*** which simply concerns the warmth existing in the interactions.

"Good, good. The person that translates is very human". (Ecuadorian, woman, 45 years old)

Table 12 shows the most frequent themes with their respective interpreter's positive factors, and patients' testimonies. *Annex H* provides the complete results of the coding process regarding the positive alliance with the interpreter.

Table 12. Factors that **positively** influence the patient's therapeutic alliance with the **interpreter** in a cross-cultural context

	THEMES	FACTORS	INTERVIEW EXTRACTS
THERAPEUTIC ALLIANCE POSITIVE FACTORS (INTERPRETER)	**Assistance**	❖ Support ❖ **Help**	❖ " To speak in general in French is easier, but for the feelings…she helped me a lot".
	Above and Beyond the Professional Duties	❖ Close contact ❖ **Concern**	❖ " I feel that she does the translation with the same concern that I am saying it".
	Good quality of Communication	❖ **Communication bridge** ❖ Simultaneous translation	❖ "… and she explained exactly what I wanted to say. I do not know! With the same simple words that we use every day (laugh) she was able to explain to her what I wanted to tell".
	Human Values and Qualities	❖ Goodness ❖ **Understanding** ❖ **Patience**	❖ "…the fact of knowing that I am being understood". ❖ "Yes, patience, because here many people do not have patience. They get all upset when I ask a question but fail to clearly convey the message…".
	Hospitality and Warmth	❖ **Warmth**	❖ "Warmth. What they are ready to do for…for one".

3.2.4 Negative Alliance

Overall, regarding the negative therapeutic alliance with the therapist, 12 themes emerged as the result of the coding process (Codes ➔ Categories ➔ Themes). Several of these themes constitute the opposite of those found in the positive relationship with the therapist, which gives continuity and congruency to the results.

In regards to the negative alliance with the interpreter, one particular theme arose. This result suggests that the patient mostly perceives the presence of an interpreter in a positive manner.

3.2.4.1 Negative Alliance with The Therapist

Concerning the negative alliance with the therapist, the most important theme that negatively influences the therapeutic alliance is the inequality or ***Unequal Positions*** between the therapist and the patient. This refers to asymmetry, lack of control of the patient over the therapy, and the patient's feeling of abnormality and difference. It is important to outline that it's opposite (***Equal Positions)*** appeared as a theme for the positive alliance, even if its frequency was not the most represented.

> *" We are immigrants, with no legal documents. So they ask you to sit and wait…" (Ecuadorian, woman, 58 years old)*

The second most important factor that influences the negative alliance is the ***Poor Quality of Communication*** which brings understanding and expression problems. It's contrary (***Good Quality of Communication)*** equally appeared as a theme for the positive alliance even if its percentage was not the most exemplified. ***Poor quality of communication*** brings up all the communication issues in a cross-cultural context regarding either the lack of the presence of an interpreter in the session, or the presence of a non-professional interpreter in the session when the therapist and the patient do no share a common language.

"You cannot make yourself understandable as you would like. Or the other understands something different". (Colombian, woman, 40 years old).

Other themes created, concerning the negative therapeutic alliance with the therapist, were ***Lack of Dynamism in the Therapy's Methods, and Disinterest in the Patient's Well-being.*** While the first theme refers to a lack of dynamism in the way of developing the session, as its names indicates it, the second one talks about the patient's perception of the therapist as a person with an economic concern and thoughtlessness of the patient's interest.

"Sessions where you sit down and just talk…make me think whether they will work or not." (Colombian, woman, 40 years old)

"…like if the fears that I felt had no reason to exist". (Colombian, woman, 34 years old)

The last most frequent themes in this topic were ***Lack of Emotional Bond*** and ***Lack of Recognition of the "Whole Person".*** For the first one, its contrary, (***Emotional Bond***), had an important representation in the positive side. ***Lack of Emotional Bond*** evokes in the patients a feeling of insecurity and mistrust.

"…many people are afraid of going to the doctor because you do not know what he is going to tell you. Is he going to dare you?" (Ecuadorian, woman, 40 years old).

Finally, ***Lack of Recognition of the "Whole Person"*** means devaluation, discrimination, and judgmental attitude. These are topics of high sensitivity for an immigrant patient who finds himself in an effort to be integrated into the host society.

"...so I always felt like if she, she did not value me". (Colombian, woman, 34 years old)

3.2.4.2 Negative Alliance with The Interpreter

The only factor that constitutes the negative alliance between the patient and the interpreter is ***Lack of Professional Ethics***, which refers to breaking confidentiality. In this case, it is important to state that the interpreter referred to a non-professional interpreter who disclosed private information of the patient to another member of the community.

"Well, one time, I had one…one appointment to which I went due to problems that I had with the partner I was living with. But at the appointment, Maria (=the interpreter) was not there, so they gave me someone else (=another employee from the same institution). So, I spoke about a situation that I was going through with my partner, and she divulged it. So, I spoke to my therapist and told her: I thought I could trust. But that lady had the indiscretion to tell to my partner". (Ecuadorian, 47 years old)

Events of this manner remind us of the impact of the interpreter on the patient's treatment and health development, according to its type.

Table 13 shows the most frequent negative themes with their respective factors, for the therapist and the interpreter, illustrated by the patients' testimonies. *Annex I* provides the complete results of the coding process regarding the patient's negative alliance with the therapist and the interpreter.

Table 13. Factors that **negatively** influence the patient's therapeutic alliance with the **therapist** and the **interpreter** in a cross-cultural context

	THEMES	FACTORS	INTERVIEW EXTRACTS
THERAPEUTIC ALLIANCE NEGATIVE FACTORS (THERAPIST)	**Unequal Positions**	❖ **Asymmetry** ❖ Lack of control over the therapy ❖ **Feeling of abnormality** ❖ Feeling of difference	❖ "The psychiatrist cannot be above the patient and the patient cannot be below… ". ❖ "If he says that you are crazy, you are messed up for all your life. And for the society".
	Poor Quality of Communication	❖ **Understanding problems** ❖ Expression problems	❖ "…either by signs or something, but one goes anyway doubtful, because many things that are not captured, one asks himself, did she say that or is this correct?".
	Lack of Dynamism in the Therapy's Methods	❖ **Lack of dynamism**	❖ "It is mediocre just to talk. …Movement, expression and creativity are missing. A dialogue but otherwise".

	THEMES	FACTORS	INTERVIEW EXTRACTS
THERAPEUTIC ALLIANCE NEGATIVE FACTORS (THERAPIST)	**Disinterest in the patient's well-being**	❖ Economic interest ❖ **Thoughtlessness of the patient's interest**	❖ "…like if she did not listen to my needs as a patient, my expectations".
	Lack of Emotional Bond	❖ Insecurity ❖ **Mistrust**	❖ "At first I felt like she did not believe me…like if she considered that I was lying".
	Lack of Recognition of the "Whole Person"	❖ Devaluation ❖ **Discrimination** ❖ **Judgmental attitude**	❖ "Sometimes I don't know if it is racism, because we are immigrants, because we have no papers…" ❖ "… sometimes they misinterpret and one is judged."
THERAPEUTIC ALLIANCE NEGATIVE FACTORS (INTERPRETER)	**Lack of Professional Ethics**	❖ **Breaking confidentiality**	❖ "Well, one time, I had one appointment …but Maria (=the interpreter) was not there, so they gave me someone else … and that lady had the indiscretion to tell to my partner ".

3.3 Factors that Promote and Demote The Therapeutic Alliance In a Dyadic and Triadic Setting

Concerning the positive relationship with the therapist, 10 themes emerged to describe the factors that promote the therapeutic alliance in a *triadic setting* and 12 themes emerged in reference to the *dyadic setting*. The first interesting upcoming observation, while comparing these two settings, is that 9 out of the 10 themes of the triad belong also to the dyad, even if they have different frequencies. However, the *dyadic setting* counts with additional factors which are more relevant to the encounter only with the therapist such as ***Equal positions*** and ***Satisfaction of Serviced Received.*** The only theme appearing in the dyad that could have been also pertinent in the triad was ***Professional Ethics***.

If I discern the force of the frequencies, the factors that most promote the therapeutic alliance with the therapist in a *dyadic setting* are evoked by themes, which involve a human contact and sensitive support, such as ***Hospitality and Warmth (15%)*** and ***Emotional Bond (12%)***.

> *"Especially, the trust that she gives me, so I can speak about everything. Everything, everything! (Chilean, man, 40 years old)*

Besides, the theme ***Above and Beyond Professional Duties 11%*** was significant**,** which was already cited as having an important impact in the positive relationship while bringing elements that imply going further and doing more than what prescribed by the framework.

> *"From that day ... he has done things for me that no one else would have done". (Guatemalan, man, 53 years old)*

In *the triadic setting*, the factors that promote the alliance are induced principally by the theme ***Assistance (18%)*** calling the factors help and support to the front line. In the same manner, factors that touch humanity and sensitivity are recalled as well in the presence of the interpreter through themes like ***Human Values and Qualities (13%)*** and ***Above and Beyond***

Professional Duties 11%. Finally, results put forth ***Good Quality of Communication*** as an important element in both settings, being more significant in the triad (10%) than in the dyad (3%).

> *"Yes, I think it is important a good communication with the therapist". (Colombian, woman, 34 years old).*

In referring to the positive relationship with the interpreter, 6 themes emerged to describe the factors that promote the therapeutic alliance in a *triadic setting*. These analyses were not applicable to the *dyadic setting* as no interpreter is present in this type of context. ***Assistance*** was significantly the most important theme with a percentage of ***38%***. Comparing with findings above it means that, in a *triadic setting,* ***Assistance*** is the theme that brings the most important factors that promote the patient's therapeutic alliance with the therapist and the interpreter as well.

> *"I am sure they helped me a lot to be steady". (Ecuadorian, woman, 45 years old)*

In short, results reveal that the factors that positively influence the therapeutic alliance with the interpreter are entirely contained in the group of factors that positively influence the relationship with the therapist in both settings, *dyadic and triadic* as seen in Table 14.

Table 14. Dyad vs. Triad: Factors that positively influence the therapeutic alliance (TA)

	TA Positive Factors (Dyad)	TA Positive Factors (Triad)
Therapist	• Hospitality and Warmth (15%) • Emotional Bond (12)% • Above and Beyond Professional Duties (11%) • Health Improvement and Change (7%) • Human Values and Qualities (6%) • Assistance (6%) • Equal Positions (6%) • Satisfaction of Serviced Received (6%) • Conflict Resolution Guidance (4%) • Permanency During Accompaniment (4%) • Professional Ethics (4%) • Good Quality of Communication (3%)	• Assistance (18%) • Human Values and Qualities (13%) • Above and Beyond Professional Duties (11%) • Good Quality of Communication (10%) • Hospitality and Warmth (9%) • Health Improvement and Change (7%) • Emotional Bond (4)% • Conflict Resolution Guidance (4%) • Authenticity in Being/Doing (3%) • Permanency During Accompaniment (3%)
Interpreter	Not applicable	• Assistance (38%) • Above and Beyond Professional Duties (16%) • Hospitality and Warmth (8%) • Good Quality of Communication (8%) • Human Values and Qualities (5%) • Conflict Resolution Guidance (5%)

In regards to the negative relationship with the therapist, 3 themes emerged to describe the factors that demote the therapeutic alliance in a *triadic setting,* and 8 themes emerged in reference to the *dyadic setting*. In the triad, the theme ***Poor Quality of Communication*** was significantly the most important one with a frequency of ***54%***. It is important to note that its opposite, ***Good Quality of Communication,*** was named when evoking the positive factors.

"... it was a little bit difficult because I had the feeling she could not understand me... you are never sure if they understand when you speak French". (Chilean, woman, 42 years old)

This means that understanding difficulties and expression problems highly demote the therapeutic alliance between the patient and the therapist in a *triadic setting*. This point is very valuable when noting that most interpreters in this study were non-professional.

In the dyad, ***Unequal Positions (35%)*** brings the most relevant factors in demoting the relationship with the therapist. Its opposite ***Equal Positions*** was called when referring to the positive factors. This suggests that the asymmetry between the patient and the therapist, the patient's lack of control over the therapy, and the patient's feeling of abnormality and difference highly demote his relationship with the therapist in a *dyadic setting*.

"The word of psychiatry which is incomprehensible for the patient". (Colombian, woman, 40 years old)

Referring to the negative relationship with the interpreter, one theme emerged to describe the factors that demote the therapeutic alliance in a *triadic setting*. These analyses were not applicable to the *dyadic setting* as no interpreter is present in this type of context. This only theme ***Lack of Professional Ethics*** refers to breaking confidentiality of a non-professional interpreter as already mentioned. Table 15 exemplifies the negative factors in the dyad vs. the triad.

In conclusion, when comparing the positive and negative factors, these results suggest that (while there exists a commonality of themes in the structure of the therapeutic alliance in a *dyadic vs. triadic setting*) help/support, security/trust, and good quality of communication imply the most important factors that positively influence the therapeutic alliance when having the assistance of an interpreter. On the other hand, humanity, emotional care, equality, beyond support, and health change represent the most important factors that positively influence the therapeutic alliance when no interpreter is present in the session. The complete therapeutic

alliance factors' frequencies and its corresponding themes for the dyadic and triadic setting could be observed in *Annex J*.

Table 15. Dyad Vs. Triad: Factors that negatively influence the therapeutic alliance (TA)

	TA Negative Factors (Dyad)	TA Negative Factors (Triad)
Therapist	• Unequal Positions (35%) • Lack of Dynamism in the Therapy's Methods (19%) • Disinterest in the Patient's Well-being (12%) • Inhospitality and Lack of Warmth (8%) • Lack of Recognition of the « Whole Person » (6%) • Lack of Health Improvement and change (6%)	• Poor Quality of Communication (54%) • Unequal Positions (18%) • Lack of Emotional Bond (18%)
Interpreter	Not applicable	• Lack of Professional Ethics (100%)

3.4 Link Between Change (Health Improvement) and The Therapeutic Alliance as perceived by The Patient

3.4.1 Quantitative results

Change is correlated with therapeutic alliance ($r_s = 0.73$, $P < 0.05$). As Graphic 7 shows, this means that the stronger that therapeutic alliance is the more change (health improvement) will be observed during the treatment which corroborates the literature (Gaston, 1990; Horvath & Bedi, 2002; Luborsky, 2000; Martin et al., 2000).

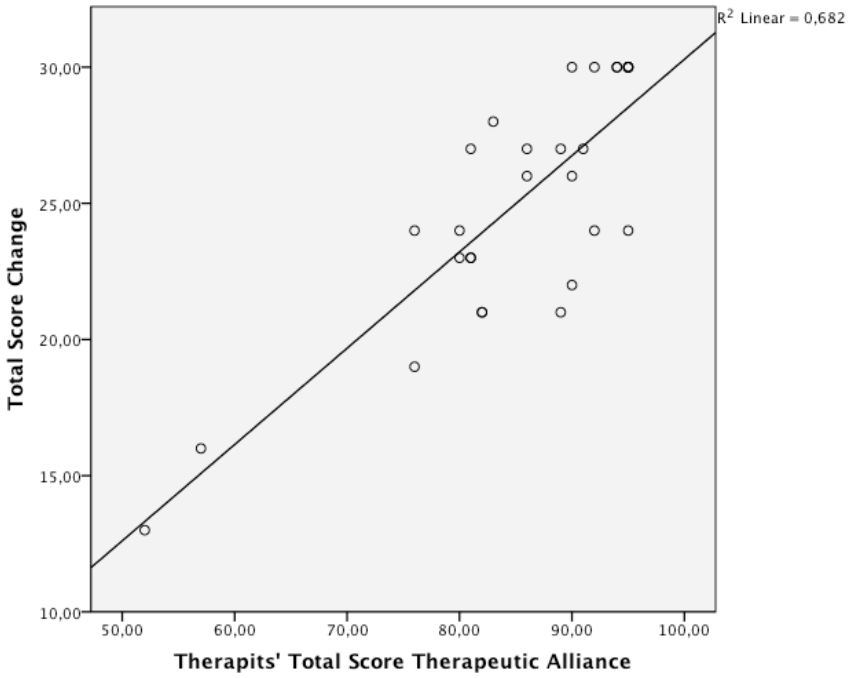
. This correlation is still meaningful with a restricted sample (without the extreme data given by three individuals considered outliers): ($r_s = 0.68$, $P < 0.05$) (See Graphic 8).

The same analyses were done individually with each of the 4 a priori defined alliance dimensions previously cited and described (*Nurturing, Relationship, Security, and Assistance*) and the results did not differ in relation to the *Total Score Change*.

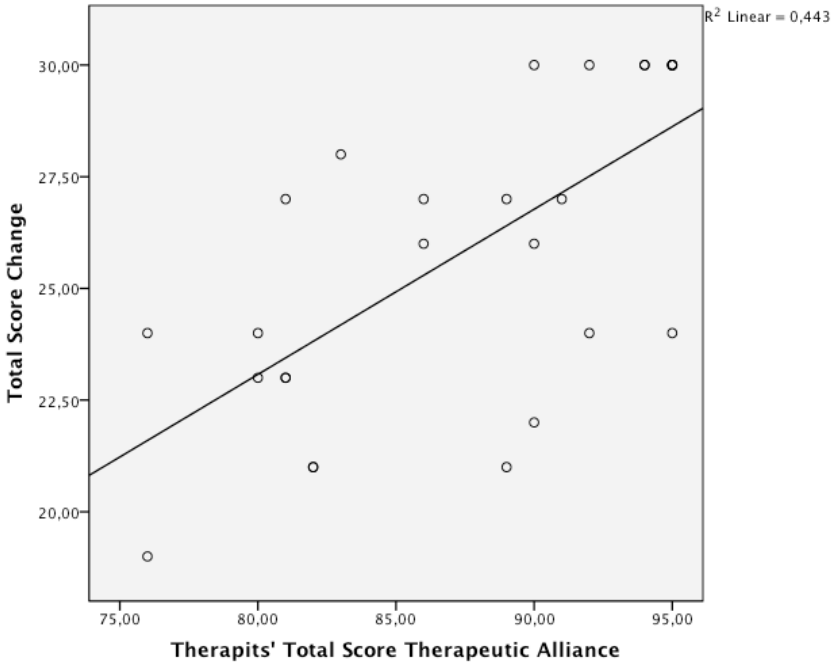
3.4.2 Qualitative results

According to the results of this phase, there exists a link between change (health improvement) and therapeutic alliance. The theme ***Health Improvement and Change*** emerged with a frequent percentage ***(7%)*** when describing the factors that positively influence the therapeutic alliance with the therapist. This theme refers to the efficacy of the therapy, the progress, and change in the patient's health. Indeed, its opposite, ***Lack of Health Improvement and Change (4%)***, appeared in the results to describe that lack of change influences negatively the relationship with the therapist. In conclusion, change is an important factor for the patient when establishing a positive therapeutic alliance with the therapist.

Health Improvement and Change did not appear when related to the interpreter, which is not surprising when considering that change is a direct responsibility linked to the therapist's role.



Graphic 7. Scattergram therapeutic alliance vs. change (all sample included)



Graphic 8. Scattergram therapeutic alliance vs. change (restricted sample included)

3.5 Relationship Between The Strength of The Therapeutic Alliance and The Hispanic American Patients' Different Demographic Data. Relationship Between The Strength of The Therapeutic Alliance and some variables inherent to the setting.

First of all, no relationship was found between the strength of the therapeutic alliance and the different demographic data of the participants. For example,

- The strength of the therapeutic alliance between the therapist and the patient does not differ when this last one has a legal status (*Mdn* = 89.0, IQR = 12.0) or illegal status (*Mdn* = 84.0, IQR =19.0), U = 256.500, z = -0.698, p = 0.485. In consequence, according to these results, the patient's residence status does not influence the therapeutic alliance strength between the therapist, and his patient, from the point of view of this last one.

- Regarding the patient's length of residence in Switzerland, it does not influence the strength of the therapeutic alliance with his therapist. χ^2 (4) = 0.554, P = 0.968; neither does the therapy/treatment's length influence the strength of the therapeutic alliance χ^2 (4) = 1.425, p = 0.840.

- Concerning the age of the patient, the correlation with the therapeutic alliance is weak, meaning that there is not a strong relationship between the patient's age and the strength of the therapeutic alliance (rs = 0.46, P < 0.05).

Secondly, no relationship was found between the strength of the therapeutic alliance and some variables inherent to the setting. For example,

- Concerning the type of interpreter, the strength of the therapeutic alliance between the therapist and the patient does not change according to the type of interpreter. This means that, for example, the strength of their relationship does not vary when there is a non-professional interpreter (*Mdn* = 85, *IQR* = 8) (e.g., family member, institution's

employee) in the session, or when there is a professional interpreter (*Mdn* = 88, *IQR* = 18), $U = 21$, $z = -0.131$, $p = 0.896$.

- Concerning the language of the session, no impact over the therapeutic alliance was observed, if the session takes place in Spanish, French, English, or if it is bilingual (French and Spanish). $\chi^2 (4) = 6.059$, $p = 0.195$.

- Regarding the therapist's origin and/or mother tongue, the strength of the therapeutic alliance between the therapist and the patient does not differ if this first one is Spanish speaker or not. $\chi^2(2) = 2.820$, $p = 0.244$.

No significant results were obtained from the interaction between those elements. In conclusion the strength of the therapeutic alliance is neither influenced by the patient's age, the patient's residence status and its length, nor by the language of the session, the therapist's origin or mother tongue, and the type of interpreter (in triadic frameworks).

SIXTH CHAPTER: DISCUSSION

1. Hispanic American Patients and Therapeutic Settings

In cross-cultural health, the Hispanic American community prefers to seek medical health services rather than psychotherapeutic. However, there are often explicit or implicit psychological issues that accompany their referrals. Many medical visits hold underlying mental health issues, even when they are not the principal reason for seeking services. Migrants that are in an illegal status, principally request medical services due to anxiety and stress caused by their poor living conditions (Valli, 2003). For legal migrants, narratives reveal difficulties in the relationships within their families that are exacerbated by migration. Hispanic American patients have the tendency to seek health services in emergency and for tangible reasons. This could explain why the first contact or help request is done through general practitioners and due to psychosomatic difficulties (e.g., stomach or back ache, insomnia).

According to the statements of different therapists in Lausanne, their role in establishing a therapeutic alliance with Hispanic Americans is strongly linked to obtaining a treatment adherence and compliance with the appointments. However, the Hispanic patient has a strong tendency to drop-off therapy or to miss appointments, finding an alternative support in his compatriots, or in self-medication (Besson et al., 2007). From my point of view, on the one hand, this behavior is closely related to the living conditions created by the illegality. Attending a session costs too much in time and in working hours, when one's income supports a very modest lifestyle and / or family in another continent. This is especially so, when there is no health insurance that covers a main portion of the expenses. Furthermore, I can imagine that a patient would be psychologically and physically unavailable to follow a treatment/intervention when his principal concern is to find a job to survive, avoid being caught by the immigration authorities, and/or find shelter. On the other hand, in the medical field, underserved urban Hispanic patients reported the lack of explanations regarding

potential side effects as a factor that negatively impacts compliance with their treatment (David & Rhee, 1998).

When describing the Hispanic American Patients in Switzerland, I could classify them in two groups: the illegal and the legal. Each group has an important role in determining the type of socio-demographic features that characterize each of them and the migration conditions in which the individuals carry out their migration path. The group of illegal Hispanic Americans resides in Switzerland with no valid permit and the government is not formally aware of their presence in the country. According to the literature review and the health professionals interviewed in Lausanne, most Hispanic Americans belong to this group. Single women who often have entrusted the care of their children to a family member in their home country mainly constitute this group. These mothers engaged in migration projects with the main purpose of improving the family's financial situation. They often come from underprivileged social levels and have only elementary education. They join the work force in the host country through baby-sitting and cleaning jobs. These women frequently go through psychosocial and economical precariousness mainly due to their undocumented status. This increases, in consequence, their psychological and physical vulnerability.

The group of legal Hispanic American who reside in Switzerland is documented and the government is formally aware of their existence in the country. Official students and international company's employees compose this group, on the one hand. On the other hand, spouses of Swiss nationals citizens belong to this group, in many cases women with the project of starting a family.

Paradoxically, the group of legal Hispanic Americans is the most represented in this research study with 65% of participants. While this percentage was somewhat lower during the quality phase of this study (55% of interviewees), I wonder why there is such a discrepancy when compared to the reality in Switzerland? I suppose that Hispanic Americans with no legal status are more reluctant to participate in research studies due to fears associated with their clandestine life conditions. Others may have lied about their real status because they were afraid of revealing their illegality. This is exemplified by a participant who claimed

different legal status in the questionnaire and during the face-to-face interview (see Table 16, *participant # 6, Dyad 1*).

Table 16. Participants and their residence status in Switzerland

Participant	Institution	**Residence status** (as indicated in the questionnaire)	**Residence status** (as indicated in the interview)
1. Dyad 1	DG0-Policlinique	Legal: Permit	Legal: Permit
2. Dyad 2	DG0-Policlinique	Legal: Permit	Legal: Permit
3. Triad 2	DG0-Policlinique	Illegal	Illegal
4. Triad 1	Appartenances	Illegal: Permit request	Illegal: Permit-request (no visa needed to enter Switzerland, but stayed illegally after due date.
5. Triad 1	HEL	Legal: Permit request	Legal: Permit request
6. Dyad 1	PMU-Générale	Legal: Permit	Illegal: Requesting nationality in Spain.
7. Dyad 4	PMU-Générale	Illegal	Illegal
8. Dyad 5	PMU-Générale	Legal: Permit	Legal: Permit, but entered in Switzerland illegally.
9. Dyad 1	PMU-Psy Liaison	Legal: Permit	Legal: Permit
10. Dyad 1	Point d'eau	Illegal	Illegal
11. Triad 1	Point d'eau	Illegal	Illegal
12. Triad 2	Point d'eau	Illegal: Permit request	Illegal: Permit request through marriage, but entered illegally.
13. Triad 3	Point d'eau	Illegal	Illegal: Requesting a permit in Spain.
14. Dyad 1	PROFA-Planning Renens	Illegal: Permit request	Illegal Permit request
15. Dyad 1	Private Practice (Psychiatrist)	Legal: Citizenship	Legal: Citizenship
16. Dyad 4	Private Practice (Psychologist)	Legal: Citizenship	Legal: Citizenship
17. Dyad 7	Private Practice (Psychiatrist)	Legal: Citizenship	Legal: Citizenship
18. Dyad 8	Private Practice (Psychologist)	Legal: Citizenship	Legal: Citizenship
19. Dyad 9	Private Practice (Psychologist)	Legal: Citizenship	Legal: Citizenship
20. Dyad 10	Private Practice (Physician)	Legal: Citizenship	Legal: Citizenship

Others have been in an illegal status before obtaining a permit. This is illustrated by *participant # 8, Dyad 5*. Individuals like this have previously experienced precarious situation. Another reason for this discrepancy could be explained by the fact that 18% of participants came from private practice offices. As previously cited, the demographic characteristics and health issues differ from private practice to public institutions. Patients in private practice appear to have more stability regarding their legal status and migration conditions.

While life conditions change considerably depending on the legal status, overall migration seems to create a sort of vulnerability among the Hispanic American community and I believe among other migrant populations. One the one hand, fragility emerges from separations and rupture from their loved ones when leaving their home countries. Social fragility begins from the uprooting, from the loss a previous culture, from a "desculturation" (Ortiz, 1940). On the other hand, when arriving to the host countries, it is exacerbated by difficulties of social, linguistic, economic, and professional/occupational integration in the host country. These difficulties become barriers in their "acculturation" process or acquisition of a different culture (Ortiz, 1940).

When exploring the cross-cultural health encounters, suffering is an element present in the Hispanic American migrants' narratives. Suffering in different degrees and forms, seems to often accompany migration projects regardless of the legal status, especially those that are long term. Cultural shock, cultural identity changes, perceived loss of family, family history, geography and social environment may contribute to depression (Bhugra, 2003) in the Hispanic American community and in many migrant communities from diverse origins. So, I could infer that suffering caused by migration dynamics does not specifically belong to a certain type of residence status or cultural group.

Hispanic American migrants in this study are from a sedentary nature. Once they are installed in the host country, they remain several years with or without a residence permit. These sedentary tendencies could be observable as well in their therapeutic rapports with the health care institutions. As soon as the Hispanic Americans find a place that welcomes them, they seem to establish a bond that lasts for several years. In fact, most participants have

contacted the same different institutions for diverse reasons for more than two years. The Hispanic American community has manifested a long history of relationships with several health institutions in Lausanne, especially with *The Water Point Association (Association Point d'Eau)*. For example, in this institution, 83% of consultants are old patients from which almost half belong to the Hispanic American population.

The history of migratory movements reveals the existence of an alliance between the European and the Hispanic American countries, of a reciprocal relationship between two continents; a relationship with positive or negative outcomes according to each epoch and life story. As illustrated by *the four clinical vignettes*, Rebeca followed this history to undertake her journey. She did not decide to leave to go anywhere in the world, she left to a country that she had hear "could host" her. Juana and Rosa followed this trend. They emigrated where migrant networks and extended family would facilitate the arrival and first contact with the foreign country. Switzerland became their targeted host country, but for Rebeca's children, as for many of their compatriots, Spain became the integration door to Europe through the acquisition of legal documents. For this reason, some Hispanic American migrants find themselves going back and forth between both countries searching for financial and legal stability; or splitting their families in both nations as illustrated by Rebeca's story.

When analyzing these vignettes, a first aspect that I want to consider refers to the circumstances that surround migrants when arriving to Switzerland. Migration movements differ according the person's socio-demographic characteristics (e.g., education, social class, ethnicity, etc.). At the same time, these characteristics influence the quality of the first contact established with the host country. For example, in the case of illegality, the immigrant searches all means to force a relationship with a country that rejects him (e.g., Rosa's migrant network). No multiculturalism is possible because the system of beliefs and behaviors of the host country does not recognize and respect the presence of diverse groups (C. Rosado, 1996). This situation is completely opposite in the case of legality, because the immigrant first contact with the host country is established through relationship agreements that are evident through legal documents (e.g., Camila's marriage with a Swiss citizen), facilitating the

transculturation process or reciprocal cultural exchanges (C. Rosado, 1996). I believe that a permit or its denial explicitly carries with it a meaning of acceptance or rejection, of inclusion or exclusion. At the same time, the residence status can facilitate the type of bond that migrants keep with their home countries and loved ones. In the case of Hispanic Americans, the family and friendship bonds maintained with their home countries seem to be strong. On the other hand, those that are illegal often nurture the relationship with loved ones abroad through money transactions and frequent phone calls, especially when a physical encounter is not possible.

It is interesting to observe that the four migratory projects were explicitly built around children, which corroborates previous research findings (Riaño, 2003). Nevertheless there is a main difference: frequently, in illegal movements children are a reason for migration while in legal movements they are a fruit of migration. Three of these mothers (accompanied by their husbands or alone) emigrated searching to improve their children's well-being through stable finances and education. The fourth one emigrated with the purpose of funding a family. This a clear demonstration of the Hispanic American values regarding *family orientation* and *allocentrism* (La Roche, 2002), which could be as well observed in the extended family's strong support that made their journey real and its conditions possible. Despite this family unit, two of these women have already experienced rupture and abandonment in the relationship with their husbands/partners. For them, it was clear that they did not want to retort this history with their own children as manifested by their efforts to make possible a reunion project. This fact validates previous research results that reveal that family grouping is one of the main reasons of migrations coming from the South (Bolzman, 2007).

The frequent existence of the "heroic return" (Métraux et al., 2003) of Hispanic American migrants, in these cases appears to be strongly related to their new relationships and family roots in the host country. The return project weakens if the children make part of the migratory journey (Rosa's case) or if a reunion with children left back home is possible in Switzerland (Rebeca and Juana's case). This is particularly true if a couple relationship (e.g., marriage) has facilitated a social integration as it happened for Juana. Paradoxically, for Camila the project

to return is present in her heart. Not as "a heroic return", but as an "existential return" to die in her motherland. For illegal migrants, future projects are sometimes utopic when the present time depends on an answer to a permit request, as illustrated by Rosa's case.

An aspect that seems to be critical in the hidden occupational integration of undocumented migrants in Switzerland is gender. The illegal job market offers opportunities in activities that are performed by women (e.g., cleaning, baby-sitting). Rebeca's children immediately experienced this imbalance when entering Switzerland, which caused a new family separation after their reunion had been possible. While her daughter found employment and was able to stay with her in Switzerland, her son had to find other opportunities in Spain. It is important to outline that an occupational integration brings along an economic and social integration that in consequence reduces precariousness (e.g., Juana's case).

Concerning the relationship with the health institutions in Lausanne, the place chosen when requesting health services confirms a history of alliance between this particular institution and her community of origin (e.g., Rebeca's case). An alliance that is strengthened not only by interventions, but also by interactions that often consider their whole being through the care of her physical and emotional needs. As previously mentioned, Hispanic American patients, consistently request services when in an emergency or when a self-medication has failed (e.g., Juana). On the one hand, I suppose that self-medication reduces expenses, saves time, and channels possible apprehension feelings related to the meeting of a health professional. On the other hand, I think that consulting in emergency after having an illness that has lasted several days suggests that the patient feels obligated to contact a professional and establish an initial therapeutic relationship, which seems unwanted due to fears often associated to residence status and race discrimination.

It is clear that in unsecure environments provided by these circumstances, the patients have more tendency to avoid any type of therapeutic relationship or are less capable of establishing therapeutic alliances (Rieben, 2012). In this case, even if it is a one-time encounter, Juana's initial contact is forced by her physical deterioration. When these types of medical health practices are observable in patients regarding their medical issues, more

resistance could be expected when psychological issues appear. For psychological difficulties, an emergency is less tangible, which may cause a delay in searching for support. This is the case in particular for those with limited access to health services (e.g., no health insurance) or those who have no previous relationship with mental health providers as the case of Rosa illustrates it.

When observing the different clinical vignettes, it is interesting to note that while for Rebeca, with an illegal status, a positive therapeutic alliance implies going above and beyond (e.g., closeness), for Camila, with a legal status, the alliance involves more of guidance (e.g., promoting insight in her thinking). This suggests that whereas the legality or illegality does not influence the strength of the therapeutic alliance, it could influence the factors that constitute it. This means that the illegal status of a patient brings out different needs from the relationships with the therapist. This was already proven regarding communication and treatment development (J. W. Rosado & Elias, 1993). However, because the objective of this research was to find common factors in cross-cultural health through the example of the Hispanic American community, further analyses concerning the factors that promote or demote the therapeutic alliance according to the legal status will not be conducted.

From another perspective, in a cross-cultural encounter, similarities between the therapist and the patients (e.g., origin and/or language) seem to facilitate their relationship, which is built in a sort of "pre-existent" alliance. When this it not possible, a *community interpreter* was identified as a precious resource in creating a bridge with the therapist for the transmission of emotions, and the promotion of listening and understanding (as expressed by Rosa). In addition, for this patient, the presence of an interpreter enables safety/security feelings, while helping her to be more authentic.

Finally, I could not finish this subchapter without evoking the alliance between this study's participants and this researcher. Being born and raised in Colombia, a "pre-existent" researcher-participant alliance might have facilitated the patients' openness when providing information and this investigator's interpretations of results. When observing my position as researcher, sometimes I saw a pseudo interpreter who aims to establish a knowledge bridge

and a linguistic bridge between two cultures into spheres: the first one, regarding two social cultural systems (Switzerland and Hispanic America); and the second one concerning two health system components (Therapists and Patients). At times, I perceived myself as an interpreter who translates to the health professionals and intends to give a sense to what is valuable for the patients regarding a therapeutic relationship.

Now, that the lecture has a good understanding of the Hispanic American community and migratory worlds that surround their journeys, I will continue the discussion focusing on the specific research questions of this study, while considering the cross-cultural health therapeutic settings and therapeutic alliance factors.

2. Study of The Therapeutic Alliance

While quantitative results showed that the strength of the therapeutic alliance between the therapist and the patient does not vary from a *dyadic setting* to a *triadic setting*, qualitative results permitted the identification of positive and negative factors that promote or demote the therapeutic alliance in each setting. From my point of view these findings do not represent incongruity, but show the necessity of mixed approaches to obtain complementary data.

Furthermore, the qualitative phase of this research facilitated the recognition of factors that positively or negatively influence the therapeutic alliance in a cross-cultural context. These factors encompass the patient's relationship with his therapist, and with his interpreter when this last was present. The dimensions that existed a priori in the Therapeutic Alliance Questionnaire for Migrants – Health Professional's version (QALMS-PS), which is the quantitative instrument used in this study, emerged again in the results along with new themes that guided me to the identification and description of its factors.

Previously identified aspects that strengthen the therapeutic alliance in monocultural and monolingual settings appeared, as well, as important factors in a cross-cultural context during

this study. Interestingly, most of these aspects cited by Bachelor and Horvath (2000), Bedi et al. (2005), Posada Saldarriaga (2009), and Ward (2000), and extracted from the patient's perspective, are represented in the 3 most frequent themes of this research: ***Hospitality and Warmth, Human Values and Qualities, and Emotional Bond.*** One can infer from the results that there exist some basic factors that enrich the therapeutic alliance with the patient, which are inherent to any encounter no matter its context. At the same time, findings from this study show that some other factors have more amplitude in a cross-cultural setting or are unique to this type of framework.

Each theme is accompanied by its frequency, which was determined by the sum of frequent sources and/or frequent references in the coding process. This means that a degree of importance was given to the number of times a theme appeared for each participant and among all the participants. Frequencies (quantitative figures) were added to the qualitative results for reasons stemming from two areas: research and clinical. From a research perspective, the identification of factors was linked as well to the quantitative instrument. Both instruments quantitative and qualitative intended to identify therapeutic alliance factors. For this reason, the determination of the most frequent factors could have facilitated an exchange between results from both methodological approaches, while allowing the possible recognition and pertinence of the a priori alliance dimensions that inspired the construction of the QALM-PS. However this was not possible because the questionnaire identified only one therapeutic alliance dimension, making the recognition of factors unachievable. From a clinical perspective, when it comes to the establishment of therapeutic relationships, I believe that the health professionals' awareness of the most frequent factors that are sensitive among all patients could facilitate the practical application of these results.

2.1 Therapeutic Alliance: Basic Factors

The theme ***Health Improvement and Change*** and the theme ***Assistance*** are composed of factors that positively influence the therapeutic alliance in both monocultural/monolingual and

bicultural/bilingual (cross-cultural) settings. These findings corroborate statements from diverse authors, which affirm that, in therapy, the strength of the therapeutic alliance has an significant impact on symptom change (Polaschek & Ross, 2010; Rogers et al., 2008; Safran & Muran, 2005; Thompson, 2003). The patient's health improvement remains an important factor that circularly influences the therapeutic alliance in diverse contexts.

Regarding the ***Assistance,*** it is important to note that this element is often recalled in different alliance scales such as in the Working Alliance Inventory (Horvath & Greenberg, 1989), tool used worldwide to evaluate the therapeutic alliance, revealing its significance in therapy. However, when working with migrant patients, I think that "the assistance brings out the patients' needs that go beyond the strict psychotherapy setting" (Boss-Prieto et al., 2010, p. 16), idea directly associated to the following theme.

In a monocultural context, Bedi et al. (2005) identified aspects that could be related to the theme ***Above and Beyond Professional Duties*** (*going beyond the professional duties*) as containing an important role in the establishment of a therapeutic relationship according the patient's perspective. However, these factors (e.g., hugging the patient, meeting the patient after hours, therapist giving his personal number) could be rapidly judged by other professionals as a "blurring of the ethical boundaries" (Bedi et al., 2005, p. 320) and considered to be negative. Here in is the importance of the professional's capacity to discern what could be ethically ambiguous or therapeutically helpful for the patient. In a cross-cultural health care context, due to the patient's migration conditions (which are often non-ideal for the Hispanic American population due to precariousness, illegality, stress, lack of integration), a support that goes beyond expectations could be a key element in creating a strong alliance. This act of going beyond could be relatively simple without demanding the trespassing of professional duties. For instance, the therapist's genuine concern and effort to help the patient, or to adequately communicate with him is positively perceived by the Hispanic American community which is characterized by a family/friendship orientation where the human contact is essential in the everyday life. J. W. Rosado and Elias (1993) had already concluded, in

reference to a large review of research studies that Hispanic families are more cooperative, trustful, and stay involved if the therapist uses personal outreaching approaches.

From another perspective, results evoking the fact of *going beyond the professional duties* are consistent with Gruen, Pearson, and Brennan (2004)'s ideas of giving the physicians a public agenda and social responsibility focus on advocacy and community participation to promote the patients' health "despite the adverse effects that broader social forces, including health and social policy changes" (Gruen et al., 2004, p. 98). Yet, while there exists a high physician's civic mindedness to engage in addressing public health concerns, their willingness is not stronger than their actions (Gruen, Campbell, & Blumenthal, 2006).

From a cross-cultural perspective, the theme ***Above and Beyond Professional Duties*** evokes what was cited by Métraux (2011) regarding the importance of sometimes giving a concrete help to the patient, as for example by helping a young immigrant in finding an hourly job. The support provided to an individual who lives an intensive stress level and whose migratory conditions surpass the adaptation capacity of human beings (AteneaNetWork, 2010) appeals to the humanity that makes part our professional beings. This reminds me of a patient with whom I had one of my best therapeutic results. I used the first couple of sessions to give her some ideas on job searching, as she was totally new in the subject, and had no idea how to do it in the host country. Someone could have told me that it was not my job and that I should have referred her to a social worker. But, I realized that, thanks to this help, which was a priority in her life, we were able to establish a positive link that opened the access to a more clinical work in the conventional duties of a psychologist. However, therapists are powerless to help in certain cases, due to rules and political policies of the institution and country where the encounter takes place (Métraux, 2011).

In Switzerland, as previously mentioned, the Hispanic American migrants' difficulties are mainly related or aggravated due to their illegal status. In an effort to find some understanding and if possible some help in the middle of despair, they often find themselves requesting help from a health professional. In consequence, the health professional could find himself going beyond his basic professional duties in a way to become the advocate of the patient. The

physicians, and other therapists could not limit themselves to treat the patient's symptoms: they also need to seek for humanity, respect and dignity in their patient's living conditions (Rothenbühler et al., 2007). The fact of going beyond may support the creation of a therapeutic alliance. However, the health professional often has to juggle between the limitations prescribed by his profession and/or society and the real suffering of the patient (Bodenmann et al., 2008), especially when called to work with a human stress whose treatment highly depends on the patient's migration conditions. On the contrary, in other cases, the beyond act appears as a consequence of the demand made by an authority. This is for example the case of health professionals who are requested to provide medical certificates for asylum seekers. In accepting this request, the clinician enters in the inclusion and exclusion game of foreigners, function that goes beyond his social and professional role (Goguikian Ratcliff & Bercher, 2011).

2.2 The Therapeutic Alliance: Factors Inherent to Cross-Cultural Health Care Practice

The thought of symmetric positions between the therapist and the patient, discussed during the literature review, was brought in the results section through the theme ***Equal Positions***. I consider that the symmetry seems to be a factor that has more importance in a cross-cultural context, in my regards, due to the patient's need of feeling understood, accepted, valued, and integrated. This validates Rosenbaum's (2003) ideas when stating that, especially with linguistically and socially disqualified immigrants, a symmetric approach facilitates a human being connection. I believe that the symmetry that the patients disclose go more in the sense of Rosenbaum's definition. This means that patients search a human symmetry and not necessarily a working symmetry (therapy/patient) in their therapeutic relationships. Likewise, Métraux (2011), reveals the importance of symmetric positions through a *balanced reciprocity,* meaning equal giving-receiving in the therapeutic relationship with migrant patients. Similarly, Shonfeld-Ringel (2001) brings along these notions in multicultural practice through the concept of mutuality, meaning mutual interchange of learning experiences and

perceptions. This idea, along with the Hispanic patients' appreciation of cultural and linguistic similarities and mutual sharing in the session, verifies that sessions performed in the patient's mother tongue and with a health professional from the same background facilitates the therapeutic alliance, and most probably the treatment (Paris et al., 2005).

Findings concerning cultural and linguistic similarities unfortunately were not corroborated by the quantitative results, which is surprising when considering that for the Hispanic population the therapeutic process in Spanish might be far more meaningful due to the comfort felt when expressing themselves (Guttfreund, 1990), and when thinking that the patient's expression in his mother tongue facilitates the path to access the complexity and richness of his being. Results are even more surprising, if we take into account that the language barrier becomes a great obstacle in the creation of the therapeutic alliance, and that sessions held in other languages are not always conducted by linguistically competent therapists.

Furthermore, when referring to ***Equal Positions***, the therapists' self-disclosure seems to also have an important value for the Hispanic American patients when talking about therapeutic alliance. These testimonies relate to Metraux's idea in which he states that sometimes health professionals should talk about their own selves and their own stories, showing themselves as being equally suffering people. "When we reveal our interior plots, we demonstrate our confidence in the other and allow him to do the same"[20] (Métraux, 2011, p. 191).

Controversially, its opposite theme ***Unequal Positions,*** identified when citing the negative factors of the therapeutic alliance, touches an aspect somehow inherent to the training received by the professionals. We are often taught to be in a different position than the patient, to be the expert, the absolute holder of knowledge, while ignoring the richness and wisdom that the

[20] TOA.

patient can bring for his own therapy, and for our own professional growth. This brings once again the potlatch term used by Métraux (2011) referring to the exchange in which the practitioner becomes the owner of an infinitive power preventing any equality in the relationship with the patient. Unfortunately, in our health system "were are not equal: the asymmetry between the families and the private or public health care institutions is total"[21] (Ronsenbaum, 2003, p. 2). Probably there exists an asymmetry in the nature of the relationship between the therapist and the patient as suggested by (Singy & Weber, 2001), which is not compensated by a human type symmetry. However, I suppose that going ***Above and Beyond Professional Duties*** could bring us to a more symmetric position with the migrant patient, despite our frequently training focused on the rational and conventional professional prescriptions.

Moreover, ***Good Quality of Communication*** is a theme that brings factors exclusively related to the cross-cultural context, even if it is totally pertinent to a monocultural context too. A good, clear, and efficient communication is equally important in a *dyadic* and *triadic* setting. This means, that its existence is essential for the establishment of a therapeutic alliance with a migrant patient that seeks services with or without an interpreter. These conclusions validate the health professional's perception according to what they considered important for the therapeutic alliance with Hispanic American patients, and confirmed previous research findings (Paris et al., 2005). They stated that Hispanic patients adhere more to treatment when they can express themselves in their mother tongue, and when things are presented in a clear manner. In addition they corroborate research findings in cross-cultural health care (David & Rhee, 1998; Es-Safi, 2000; Teutsch, 2003).

The appearance of its opposite theme, ***Poor Quality of Communication*** brings up all the communication issues in a cross-cultural context regarding either the absence of an interpreter

[21] TOA.

or the presence of a non-professional interpreter in the session when the therapist and the patient do no share a common language.

The theme ***Emotional Bond*** reveals the importance of the presence of trust, empathy, and security in the health context to facilitate the creation of positive interpersonal relationships with the Hispanic American patients. Security seems to be a factor especially sensitive to this community, and inclusive to all migrant populations; therapists in Lausanne agreed with this. From a cross-cultural perspective, a previous study had already confirmed a relationship between safety and trust, and its importance in the establishment of a therapeutic alliance with Albanese patients (Boss-Prieto et al., 2010). I believe that, in a cross-cultural context, security relates more to the notion of a non-judgmental and protective environment. In the same manner, I agree that "recognition in the form of approval provides a sense of security"[22] (Métraux, 2011, p. 216). This means that the ***Lack of Recognition of the "Whole Person"*** through devaluation, discrimination, and judgmental attitude brings insecurity in the patient and represents a danger to the therapeutic alliance. These ideas refer us back to the concept of safety and the need of a "secure base" to develop positive alliances. I consider migration movements are destabilizing by their nature even if they take place in good conditions. Based on this statement, I believe that security is even more necessary in the case of migrants with low social-economic status who feel persecuted and rejected. For Hispanic Americans, who often carry an initial feeling of mistrust during first encounters, safety might facilitate overcoming the challenges that prevent them from opening themselves into a positive alliance with the therapist, particularly when possessing an illegal status.

The importance of safety in the Hispanic American population has been already documented. According to Añez et al. (2008) trust and intimacy are main values in the Latino community, among others (e.g., family orientation). Specific cultural representations could impact the person's behavior, thoughts, and beliefs. This means that, somehow, cultural values

[22] TOA.

participate in shaping what it is therapeutically important for Hispanic Americans patients. Results of this present study can be linked to findings from these authors' research when recalling factors such as trust and close contact.

Finally, it is worth noting that throughout the results of this research, factors that influence the therapeutic alliance where presented from a positive and negative perspective, evoking certain bipolarity. However, it is important to state that the dynamic of interactions of both opposite poles could be part of the same session. This means that the same encounter could have positive and negative factors that affect and transform the therapeutic alliance.

To conclude, results reveal that the factors that positively influence the therapeutic alliance with the interpreter are entirely contained in the group of factors that positively influence the relationship with the therapist in the dyadic and triadic setting. This allows me to conclude that no matter the setting (*dyadic or triadic*) and no matter the person (therapist or interpreter) the basic factors that promote any type of therapeutic alliance in a cross-cultural context are: being helped or supported, receiving more than expected, feeling a warm contact, experiencing good quality of communication, perceiving a feeling of humanity, and being guided towards resolution. These findings confirm the universality of the therapeutic alliance, effective no matter how different the therapeutic approaches (e.g., systemic, psychoanalytic, etc.) or therapeutic settings (e.g., individual, group). Overall, through these results I could infer that the therapeutic alliance relies considerably on human qualities and moral values, bringing the conception of humanity as an important need when meeting a migrant patient. Nevertheless, some questions remain: are these human qualities socially transmitted and learned? Does it belong to professional acquisitions or to the person's innate features? From my perspective, the alliance itself cannot be studied and learned, but it's a natural and spontaneous connection built in the interaction with the patient. Despite this, we could develop skills and acquire knowledge, and experiences that might facilitate the alliance creation and growth. For example, the therapist's application of specific techniques that take into account the unique characteristics of the patients, facilitates the creation of the therapeutic relationship

(de Roten, 2008). Along with this, there exist factors that positively or negatively influence this affective and collaborative bond.

In light of the above, in a cross-cultural setting, non-classic therapeutic alliance factors represent the uniqueness of this encounter. Immigrants (in this case Hispanic Americans) seem to be more in an *emotional* than in *a rational alliance* (Coleman, 2000) that could have emerged from difficulties often related to migration experiences and to the need of being integrated in the society. Treatments accompanied by emotionally charged symbols (e.g., closeness, shared meanings, warmth, informality, etc.) had also been identified as important healing factors in indigenous communities in Mexico (Good, 1994). I consider that the awareness of this matter plus the knowledge of the factors that promote the therapeutic alliance in cross-cultural settings are key points when working with patients from different backgrounds.

No relationship was found between the strength of the therapeutic alliance and the Hispanic American Patient's age. Preliminary studies focuses on the patient's perception on their therapeutic alliance, had already showed no significant correlations (at all assessments stages) between the alliance ratings and patients gender or age (Bachelor & Salamé, 2000). Likewise, no relationship was identified between the strength of the therapeutic alliance and the patient's length of therapy, confirming the existence of a therapeutic alliance for one session health encounters. These results corroborate previous findings (Ward, 2000) and are congruent when considering that the therapeutic alliance is nurtured by more transcendental factors as the ones above cited.

While my quantitative data shows no impact of the type of interpreter on the strength of therapeutic relationship, I strongly suspect that it has an impact on the therapeutic alliance that the therapist establishes with his patient. From my perspective, the lack of significant results obtained through the QALM-PS (regarding this point) brings up the limitations of this instrument, which, despite its potential, requires to be improved. The questionnaire probably needs to provide a description of each interpreter when asking the patient to determine its type.

The patients might not have the same definition of what an interpreter is, and might ignore the existence of different types.

Looking at specificities of the QALM-PS, I would suggest that the content of the questions regarding the first part (Alliance with the Therapist) be equaled to the second part (Alliance with the Interpreter). This would better allow comparing the therapeutic alliance of the patient with his therapist, and with his interpreter in a *triadic setting*, according to its type. For example, question 11: "I think my session would be more effective if I did not need an interpreter" could be removed because no equivalent exists concerning the therapist.

The QALM-PS should be improved in order to offer to all health professionals a therapeutic alliance scale adequate to cross-cultural contexts, which, to my knowledge, does not exist. The measurement of therapeutic alliance could help the therapist to better guide the patient's treatment during different stages of the therapy. Knowing the strength of the alliance with each participant could better help evaluate where changes need to be made to promote the patient's health improvement.

Results from different cited research studies have proved the importance of the presence of a *community interpreter* to facilitate the communication and understanding between the therapist and the patient, when both speak a different language and/or have different backgrounds. This is not only to help the verbal interaction, but also to assist with the mutual understanding of cultural values and representations that come along with words, attitudes, expressions, behaviors, reactions, glances, and the overall complexity of non-verbal messages.

I believe that the *community interpreter's* skills are the more suitable due to his neutrality, the specificity and uniqueness of his role, his professional knowledge and training, and his availability. All these characteristics could facilitate, accompanied by other factors, the creation of a therapeutic alliance appropriate to the type of work made in a triadic bilingual setting.

Leanza et al. (2010) shed light on the importance of training the dyad (professional-interpreter) to work together in helping migrants. I will say that in addition, there exists a need to consider the triad (professional-interpreter-patient) in this regard. This means that the patient doesn't need to be trained, but informed of the existence, role, and impact of an interpreter according to its type. During this research, I realized that in certain cases patients would rather have a family member as a translator because they ignored the existence of professional interpreters and of the limitations implied in having a relative present in the therapy. Overall, there is a "lack of awareness of the impact of language barriers on quality of care" (Bischoff & Hudelson, 2009, p. 4) that leads to the acceptance of "lower quality interpreting". I think that this unawareness is an issue that involves not only some health institutions and health professionals, but also the patients.

SEVENTH CHAPTER: GENERAL CONCLUSIONS

This research project conducted at the Psychology Department of the University of Lausanne (Switzerland) evaluated the therapeutic alliance in cross-cultural health care through the example of the Hispanic American community who requests health care services (psychological/psychiatric, medical, or social) in the region. From the patient's perspective, the therapeutic alliance was explored in two types of settings: the *dyadic and triadic setting*. The *dyadic setting* is the encounter of a therapist (health professional) and a patient who ideally share the same language. The *triadic setting* is the encounter of a therapist and a patient who speak a different language, but are able to interact thanks to the help of an interpreter.

The therapeutic alliance, relationship between the therapist and the patient, is a key concept in any kind of health treatment to predict a good outcome. The meaning of the therapeutic alliance, with its particularities in a cross-cultural context, can be redefined from this research design. I believe that the knowledge of the factors that promote the therapeutic alliance in cross-cultural settings are essential elements when referring to the therapist's skills to work with patients from different backgrounds. In this case, the patient's point of view could help us enhance our knowledge about therapeutic relationships in the health field and could guide us to the co-construction of the meaning of the therapeutic alliance.

From a qualitative point of view, and in reference to Coleman's (2000) definition, results show that the factors that enrich the therapeutic alliance with migrant patients depend more on an emotional alliance (bond) than on a rational alliance (agreements). Indeed, the positive relationship with the interpreter, and especially with the therapist relies considerably on human qualities and moral values, bringing the conception of humanity as an important need when meeting foreign patients in health care settings. These results are not surprising in communities with psychosocial and economic precarious life conditions that, in addition, have non-psychological cultures (like some underserved urban Hispanic patients), because the establishment of goals and tasks agreements might seem abstract for them, while the emotional support remains a basic need in the case of suffering. Nonetheless, these results

could be disturbing for therapeutic practices whose roots are based on strong traditional western medicine. Knowing, that western treatments were/are "mechanical and impersonal; healers are characterized by distance, coolness, formal relations, and the use of abstract concepts" (Good, 1994, p. 26).

From the Hispanic American patients' point of view, overall, the basic factors that promote the therapeutic alliance in a cross-cultural context are: being helped or supported, receiving more than supposed to, feeling a warm contact, experiencing good quality of communication, perceiving a feeling of humanity, and being guided towards resolution. When comparing with a traditional monocultural/monolingual setting, communication could be highlighted as a unique factor in cross-cultural health care practice. On the other hand, what touches humanity, symmetric rapport, security, and the therapist's act of going above and beyond his professional/conventional duties to reach the migrant patient, could be put forth as factors with more amplitude in this context.

They are specific differences in each framework. The *dyadic setting* requires factors focused more on health improvement, symmetry (equal positions between the therapist and the patient), human kindness, and support beyond expectations. The *triadic setting* implies factors inherent to the presence of a third person such as security/trust and good quality of communication. This is in addition to the help/support that is characterized in monolingual settings as well. These findings have even more power when looking at its opposites. While asymmetry (unequal positions) is the factor that most negatively influences the therapeutic alliance in a *dyadic setting*, poor quality of communication is the main factor that demotes the therapeutic alliance in a *triadic setting*. When evoking the dynamic and relational notion of *culture*, it could be said that the tension between symmetry and asymmetry allows a person to renovate himself in a perspective of cultural identity.

The therapeutic alliance with the Hispanic community is not always easy to establish due to their legal and socio-economic instability of many, which produces frequent ruptures in their lives and in their capacity to maintain engagements. Hispanic American patients often miss their appointments or dropout of their therapies due to legal difficulties, excessive

working schedules, or housing complexities. The precariousness in several dimensions, the rupture with their family links, the solitude, and the difficulties related to integration can intervene directly not only on their health state (Renteria, 2003), but also on their capacity to relate to their health professionals, and therefore on their capacity to invest in a therapeutic alliance. Along the same line, their lives' priorities drive their choices towards basic needs where a health treatment seems sometimes far from their reality and immediate benefit.

From an anthropological perspective and when considering the definition of *culture* as an element that is built through social relationships, I would say that the therapeutic alliance participates to the construction of the migrants' transculturation process, new cultural values and identity. Reciprocally, cultural values, migration movements, and present life circumstances influence the therapeutic alliance. The stress linked to these movements may influence the person's capacity and availability to establish therapeutic relationships. For instance, new emigration and working laws in Switzerland, and a world economic crisis should have impacted the number of Hispanic patients who search better life conditions in Europe and the way they relate to others.

Moreover, as seen by the identified themes, the greeting and communicating strategies used when encountering these patients have an impact when establishing a therapeutic relationship with the therapist, and furthermore with the institution. Sessions with Hispanic Americans in the health institutions of Lausanne are mainly conducted without an interpreter, which means they are done in a *dyadic setting (*for 72% of the participants in this study). These take place mostly in Spanish even though some therapists were reported to not speak or be fluent in this language. In the case of *triadic settings*, the *untrained interpreter* (institution's employee with other job position) is the type of interpreter most used for Hispanic patients, followed by the *chance interpreter* (family member or friend) and *the community interpreters* (professional interpreters).

Approximately two decades ago, the choice of the type of interpreter was influenced by the evolution of Switzerland's health policies and the creation of health networks (intra and inter institutional networks). Today, the choice of the type of the interpreter seems to be

guided by the health professionals' old practices (*untrained interpreter* = colleagues support). When the option of interpreter relies on the patient, the *chance interpreter* seems to be the first choice of Hispanic Americans, influenced by their familism value.

Health institutions in Lausanne state that the use of a *community interpreter* is restricted by the non-existence of an interpreter structure and by the lack of economic resources to pay for these services, especially in the medical field. Budgetary restraints have been identified recently (Bischoff & Hudelson, 2009) and earlier in Switzerland (Eytan et al., 1999) and probably have existed since the creation of the interpreting services in the country. This despite the fact that research studies have revealed that immigrants in Switzerland, who do not speak at least one of the national languages, have more physical and psychological difficulties than the local population (Interprèt, 2011b).

The topic related to budgetary constraints for financing professional interpreters is a current debate in the country and solutions are proposed for this service in the institutions that offer health care to migrants. However, apart from changes in health care policies, the inclusion of interpreters in cross-cultural health care practices requires as well educational changes. These consist of the institutions and health professionals' awareness of the impact of language barriers and the use of non-professional interpreters on the patient's health. Finally, an informative aspect seems necessary in regards to the patient. Patients should be aware of the positive and negative aspects about the presence of each type of interpreter before choosing the person who will serve as the linguistic and cultural bridge in their medical encounter.

Considering the therapeutic settings and communication, there is evidence that *community interpreters* are not often requested, especially in medical services. In the hospital area the *community interpreter* is requested "only after other strategies have failed, due to cost concerns and practical issues" (Weber, 2003, p. 4). In addition, the clinical professionals feel more familiar and comfortable organizing an appointment with a staff member for translation than with an external professional interpreter. The health professionals in the mental health field or psychosocial field seem less ambivalent concerning the need of an interpreter in a

cross-cultural encounter. This can be explained by the fact that the speech constitutes the principal tool of communication and work vehicle with the migrant patient (Métraux et al., 2003), and without it no treatment is possible.

In the medical field, creative resources other than the presence of an interpreter have been used to help the interaction between the health professionals and the patients when language barriers are existent. However, the use of gestures and drawings appears to be perceived by immigrants as an artificial substitution of communication instead of a complementary element (Renteria, 2003). These communication resources (mimics, drawings + translation via internet) are insufficient considering that the verbal language is the only communicational instrument capable to report the human experience in its wholeness (Métraux et al., 2003). Alternative communication techniques should be used only in case of emergency due to their limitations related to the transmission of more complex messages or subtle exchanges (Faucherre et al., 2010). Additionally, they do not represent a reliable tool of translation nor understanding. I consider that, while the drawings and gestures do not have an universal meaning, translation via the Internet reduces the complexity and richness of language to a word by word translation. Literal translation as such is non-existent because there is no identical translation from one language to other at the vocabulary level. Without contexts and cultural representations, words are empty inside. With these communication strategies, the therapist is not certain that the message has been transmitted correctly and the patient is not sure that he has clearly understood it. As a result, the advice or treatment to be followed by the patient may be wrong.

The lack of a common language or interpretation could lead to misunderstandings that often finish in conflicts. As Es-Safi (2000) stated, problems have been found in ambulatory medicine due to a medication misused or of its prescription. In addition, studies in Belgium have demonstrated that the hospitals make more analyses and tests with immigrants than with the locals. It also has to be considered that repetitive or interminable sessions due to incommunicability produce an increase in health expenses (Métraux et al., 2003). “The hypothesis according to which communication problems produce a bad management of the

health capital is verified, and the presence of intercultural mediator is recognized as a benefit"[23] (Es-Safi, 2000, p. 32).

Spanish and French share linguistic similarities. This is used as an excuse by therapists and even by patients to believe that an interpreter's presence is not as essential as it is in other languages. Therefore, the communication with Spanish speaking patients is more abused than with patients who speak languages with no Latin origin. These results validated previous findings in the country where it was stated that Spanish and Portuguese are the languages were community interpreters are least requested (Bischoff & Hudelson, 2009). However, it is disturbing to realize that sessions with no common language continue to be held between health professionals and Spanish speaking patients. In Switzerland, Fleischer (2002) had already found that "more than 20% of migrant patients do not share any common langue with the doctor and consult without a translator" (2002, p.4). This amount is quite representative when thinking that wrong treatments or diagnostics have been attributed due to communication difficulties (Fleischer, 2002). What is even more worrying when realizing that similar situations occur in other countries as the United States, where the majority of migrant patients are constituted of Hispanic Americans. A recent study revealed that physicians and nurses with "limited Spanish proficiency use these skills, even in important clinical circumstances" (Diamond, Tuot, & Karliner, 2011, p. 117).

1. Implications

Studies have already documented the link between therapeutic alliance and treatment's outcome in monocultural settings, and have identified factors that influence it as well. This study contributes to the knowledge of the particularities of the therapeutic alliance with culturally and linguistically diverse patients, specifically in regards to the Hispanic American

[23] TOA.

community. In addition, this study nurtures the knowledge of communication dynamics, therapeutic settings, and the presence of an interpreter in a cross-cultural context. This has special value when considering that in today's world, migration movements are increasing everyday and health care interventions need to adapt to globalization changes. Furthermore, this research demonstrates the relevance of the therapeutic alliance to every health care encounter, and non-exclusively to the psychological/psychiatric context. Meanwhile, it shows that the therapeutic alliance is an element that could be part of a one-time encounter between the therapist and the patient, or of several encounters.

The outcome of this study could guide the design of treatments to meet the needs of migrant communities, especially of the Hispanic American population in Switzerland through the establishment of a high quality therapeutic alliance and adequate communications means in the sessions. Further clinical and educational work should be done to develop and apply interventions based on these results. Findings of this research could be used as teaching support for training current health professionals, interpreters, and students in the health field.

This study corroborated the importance of the complementarity of a mixed methodology. While the quantitative tool measured the strength of the therapeutic alliance, the qualitative tool evaluated the factors that promote or demote the therapeutic alliance. The mixed approach allows and articulation between static data (quantitative) and dynamic data (qualitative) that activates a variable, in this case the therapeutic alliance. I think the mixed approach could better reach the complexity and richness of underlying issues belonging to migration frameworks; therefore I recommend its use.

2. Limitations

One of the limitations of this study is on the hypothetical level. The therapeutic alliance in this study was mainly positively evaluated by the patients. I suspect that health professionals could have tended to give the questionnaire to a patient with whom they have a good relationship with because this instrument indirectly evaluated them. On the other hand, I

suspect that patients with a better relationship with their health professionals or with the institution overall, more often agreed to participate in this study than those who have a negative one. In consequence, this could influence the generalization of these quantitative results and possibly had impacted the findings showing no difference regarding the strength of the alliance in presence or absence of an interpreter.

The therapeutic Alliance Questionnaire for Migrants – Health Professionals' version (QALMS-PS) is a potential valuable instrument in the field of health care services with patients of different backgrounds. It evaluates the therapeutic alliance from the patient's perspective, taking into account the presence or absence of an interpreter, and important elements relevant to a migration context. While it demonstrated its capability to measure the strength of the therapeutic alliance, it showed its limitation to identify different alliance dimensions. I lack elements to determine if the non-identification of dimensions is specifically related to the results of this research, or to the questionnaire itself. This means that it will be important to test this instrument in another context to see if dimensions can appear before proceeding to validation. However, from a statistical point of view, the unidimensionality and the presence of a general factor are perceived as important properties that a test might possess (Revelle & Zinbarg, 2009).

Another limitation concerns the lack of dialogue between the results of the questionnaires and those of the interviews. Data (from the 20 participants who participated in both, quantitative and qualitative phases) was treated and analyzed separately. The reason why this was done during my study is because results of the questionnaire show an abnormal distribution. This means that from the 55 participants, 52 evaluated the alliance in very positive terms, making it less interesting to compare the patient's alliance strength with the factors that promote or demote their therapeutic alliance with the therapist. However, a correlation between quantitative and qualitative results would be desirable in normal results conditions.

Difficulties were encountered in recruiting the expected sample size. On the one hand, this could be explained by the decrease of the Hispanic American community in Switzerland in the

last years. On the other hand, I believe that the non-direct contact of the researcher, during the questionnaires' recruitment, influenced the number of patients agreeing to participate. In this case, a direct involvement of the researcher was not possible due to the width of the study field, and due to the concern of preserving the privacy of the institutions. Less persistence and conviction may be present when the researcher has no direct contact with the participants. Likewise, therapists are often overflowed by their daily activities, or by other types of research. However, the distribution of questionnaires through a third party allows reaching a larger population. Above all, I suspect that there exists a feeling of mistrust in the Hispanic American patients that prevented them from participating. By nature, I believe that Hispanic Americans are often mistrusting people. I think this is a survival skill learned while being in unsecured environments with low social consciousness. This feeling of mistrust might also grow fostered by difficult migration conditions, especially concerning precariousness, and illegality. Finally, I have the impression that the participation of Hispanic Americans during this research was decreased by the fact of not having a concrete benefit regarding their input in the research. I can imagine thoughts like: "How is this going to be helpful for me? I do not have any immediate interested in doing this". From my perspective, Hispanic Americans significantly focus on the present moment, and give a lot of importance to what it is concrete and relevant.

This study is limited due to the cultural background of the patients, which was restricted to only one group (Hispanic American). However, it is important to outline that this group is constituted of 19 countries located in South and Central America, what enhances his diversity. Another point that I could simultaneously present as a strength and limitation comes from the linguistic diversity of this project, which was elaborated and conducted with the support of 3 languages: Spanish, English and French. While the variety of idioms permitted the realization of this cross-cultural study, some content could have been lost during translation.

Regarding the design used during this study, I could state that one of the challenges of the mixed methodology appears when findings do not complement or agree with each other. This was for example the case of results that stated that sessions in the patient's mother tongue and

with a health professional from the same background facilitate the therapeutic alliance. Quantitative and qualitative results did not arrive to the same conclusion. On the other hand, the QALM-PS could not identify the therapeutic alliance factors or dimensions, so results between both approaches could not be compared. Furthermore, the response rate for the questionnaire was rather low (30%), which can influence the results' generality as well. Concerning the analyses of the qualitative findings, a limitation refers to treatment of data that focused on the occurrence's frequency of the identified themes/factors and not in how, when and why they appeared. However, it is clear that qualitative results were explored through thematic analyses and not through discourse analysis.

3. Future Studies

Regarding the research domain, I propose two possibilities of future studies in cross-cultural health care. One is to conduct studies of this type with the most represented populations in the country, which counts with a high socio-cultural diversity in order to find what it is important for each of them concerning the therapeutic relationship.

The second possibility is to consider analyzing the therapeutic alliance based on the social fragility of diverse migrant communities and not necessarily based on their cultural background. I suspect that similarities in the therapeutic alliance exist among diverse vulnerable vs. invulnerable migrant groups, as it could be the case for legal vs. illegal Hispanic American groups. Indeed, the preliminary study that preceded this research and guided the construction of the QALM was conducted with Albanese patients. Finding the pre-existent dimensions from the questionnaire QALM in this current study suggests the presence of common therapeutic alliance factors between the Albanese and Hispanic American patients. This could better allow the generalization of results among migrants.

From another perspective, the influence of the presence of the interpreter in the therapeutic health care encounter could not be completely grasped in this study. For this

reason, I suggest a future study with a randomized control trial design to allow the comparison of the same therapist-patient dyads before and after the intervention of an interpreter.

Finally, because the growing therapeutic alliance better improves the patient's health conditions than the stable one (de Roten et al., 2004), a longitudinal study could provide a larger and more complete perspective on this manner. However due to its complexity, I would recommend that this type of this study be the product of diverse researchers' collaboration.

BIBLIOGRAPHY

Achotegui, J. (2004). Immigrants living in extreme situation: Immigrant Syndrome with Chronic and Multiple Stress (The Ulysses Syndrome). *Norte de Salud Mental, 7*(21), 39-52.

Alegria, M., & Vega, W. A. (2001). Latino mental health and treatment in the United States. In M. Aguirre-Molina, C. W. Molina & R. E. Zambrana (Eds.), *Health issues in the Latino community* (pp. 179-208). San Francisco: Jossey-Bass.

Althaus, F., Hudelson, P., Domenig, D., Green, A. R., & Bodenmann, P. (2010). Compétences cliniques transculturelles et pratique médicale. *Forum Médical Suisse, 10*(5), 79-83.

Añez, L. M., Silva, M. A., Paris, M., & Bedregal, L. E. (2008). Engaging Latinos Through the Integration of Cultural Values and Motivational Interviewing Principles. *Professional Psychology: Research and Practice, 39*(2), 153-159.

Appartenances, A. (2010). *Modèles de financements possibles pour l'accès aux interprètes.* Paper presented at the Assises romandes de l'interprétariat communautaire, Lausanne, Suisse.

ARIC. (2003-2013). Association internationale pour la recherche interculturelle, April 15th 2013, from **http://www.aulaintercultural.org/spip.php?article4708**

Association Appartenances. (2011). Appartenances Rapport Annuel Lausanne.

Association Appartenances. (2012). Interprétariat communautaire Retrieved March, 2013, from **http://www.appartenances.ch/Intermedia.html - travailler**

Association Point d'Eau. (2011). Rapport d'activité 2011. Lausanne.

AteneaNetWork. (2010). Network of psychological and psychosocial support for immigrants living in extreme situations. A global response to global problems. Retrieved July 9th, 2012, from **http://www.laredatenea.com/english/index.html**

Ayer, A. (2004). L'accès aux soins des patients allophones. *Plaidoyer, 6*, 56-61.

Ayer, A., & Gilbert, M. (2004). Droit du patient migrant: quelles sont les bases légales de la consultation médicale en présence d'un interprète? (pp. 1-10): Commission fédérale des étrangers. Résumé de la recherche CFE 03-806.

Bachelor, A. (1995). Client's Perception of the Therapeutic alliance: A Qualitative Analysis. *Journal of Counseling Psychology, 42*(3), 323-337.

Bachelor, A., & Horvath, A. O. (2000). The therapeutic relationship. In M. Hubble, B. Duncan & S. Miller (Eds.), *The Heart and Soul of Change* (pp. 133-178). Washington: APA.

Bachelor, A., & Salamé, R. (2000). Participants' perceptions of dimensions of the therapeutic alliance over the course of therapy. *The Journal of psychotherapy practice and research, 9*(1), 39.

Bagchi, A. D., Dale, S., Verbitsky-Savitz, N., Andrecheck, S., Zavotsky, K., & Eisenstein, R. (2011). Examining Effectiveness of Medical Interpreters in Emergency Departements for Spanish-Speaking Patients with Limited English Proficiency: Results of a Randomized Controlled Trial. *Annals of Emergeny Medicine, 57*(3).

Baillargeon, P., Pinsof, W.-M., & Leduc, A. (2005). Modèle systémique de l'alliance thérapeutique. *Revue européenne de psychologie appliquée 55*, 137-143.

Baker, D., Hayes, R., & Puebla Fortier, J. (1998). Interpreter Use and Satisfaction with Interpersonal Aspects of Care for Spanish-Speaking Patients. *Medical Care, 36*(10), 1461-1470.

Balint, M. (1957). *Le médecin, son malade et la maladie* (T. d. l. a. p. j.-P. Valabrega, Trans.): Bibliotèque scientifique Payot.

Barber, J. P., Connolly, M. B., Crits-Christoph, P., Gladis, L., & Siqueland, L. (2009). Alliance predicts patients' outcome beyond in-treatment change in symptoms. *Personality Disorders: Theory, Research, and Treatment*(1), 80-89.

Bauer, A. M., & Alegría, M. (2010). The impact of patient language proficiency and interpreter service use on the quality of psychiatric care: A systematic review. *Psychiatric services (Washington, DC), 61*(8), 765.

Bedi, R. P., Davis, M. D., & Williams, M. (2005). Critical Incidents in the Formation of the Therapeutic Alliance from the Client's Perspective. *Psychotherapy: Theory, Research and Practice, 42*(3), 311-323.

Beltran Avery, M. P. (2001). The Role of the Health Care Interpreter: An evolving dialogue *The National Council on Interpreting in Health Care Working Papers Series*. Chicago.

Besson, M., Desmeules, J., Wolff, H., & Gaspoz, J.-M. (2007). Automédication chez les sans-papiers latino-américains: entre le nécessaire et l'inaproprié. *Revue Médicale Suisse, 127*(32410), 1-8.

Betancourt, H., & Regeser Lopez, S. (1993). The Study of Culture, Ethnicity, and Race in American Psychology. *American Psychologist, 48*(6), 629-637.

Bhugra, D. (2003). Migration and depression. *Acta Psychiatrica Scandinavica, 108*, 67-72.

Bischoff, A., & Denhaerynck, K. (2010). What do language barriers cost? An exploratory study among asylum seekers in Switzerland. *BCM Health Services Research, 10*.

Bischoff, A., & Hudelson, P. (2009). Communicating With Foreign Language-Speaking Patients: Is Access to Professional Interpreters Enough? *Journal of Travel Medicine*(1195-1982), 1-6.

Bischoff, A., Perneger, T., Bovier, P., Loutan, L., & Stalder, H. (2003). Improving communication between physician and patients who speak a foreign language. *British Journal of General Practice, 53*, 541-546.

Bischoff, A., Tonnere, C., Eytan, A., Bernstein, M., & Loutan, L. (1999). Adressing language barriers to health care, a survey of medical services in Switzerland. *Sozial-und Präventivmedizin, 44*, 248-256.

Bodenmann, P., Althaus, F., Carbajal, M., Marguerat, I., & Kohler, D. (2010). "La enfermedad del millionario" (la maladie du millionaire). *Forum Médical Suisse, 10*(6), 102-107.

Bodenmann, P., Depallens Villanueva, S., Schoch, M., Puelma, M.-J., Pécoud, A., & Gehri, M. (2003). Etre malade et "sans papiers" à Lausanne: quo vadis? *Revue Médicale Suisse, 61*(2455), 2023-2028.

Bodenmann, P., Diserens, E.-A., Marguerat-Bouché, I., Elghezouani, A., Pasche, C., Puig, F., & Vannotti, M. (2008). Durcissement des lois sociales et santé des migrants forcés. *Revue Médicale Suisse, 181*(33602).

Bodenmann, P., Madrid, C., Vannotti, M., Rossi, I., & Ruiz, J. (2007). Migration sans frontières... mais barrières des représentations. *Revue Médicale Suisse, 3(132)*(3135), 2710-2717.

Bolzman, C. (2007). Travailleurs étrangers sur le marché du travail suisse: quels modes d'incorporation? *Journal of International Migration and Integration/Revue de l'integration et de la migration internationale, 8*(4), 357-373.

Bolzman, C., Carbajal, M., & Mainardi, G. (2007). Latino-Américains en Suisse: à la découverte de migrations méconnues. In i. éditions (Ed.), *La Suisse au rythme latino* (pp. 11-40). Genève.

Bordin, E. (1979). The Generalizability of the Psychoanalytic Concept of the Working Alliance. *Psychotherapy: Theory, Research and Practice, 16*, 252-260.

Bosisio, F. (2013). *La transplantation d'organes entre rhétorique du don et vision biomédicale du corps.* (Docteur en Psychologie), University of Lausanne, Lausanne.

Boss-Prieto, O. L., de Roten, Y., Elghezouani, A., Madera, A., & Despland, J.-N. (2010). Differences in Therapeutic Alliance when Working with an Interpreter: A Preliminary Study. *Swiss Archives of Neurology and Psychiatry, 161*(1), 14-16.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77-101.

Brisset, C., Leanza, Y., & Laforest, K. (2013). Working with interpreters in health care: A systematic review and meta-ethnography of qualitative studies. *Patient Education and Counseling, 91*(2), 131-140.

Carbajal, M. (2001). Adaptación...Integración en las Inmigrantes LatinoAmericanas Cladestinizadas en Suiza: Paradojas y Contradicciones. *Revista Electrónica de Geografía y Ciencias Sociales, 17*(94), 1-12.

Carbajal, M. (2004). *Actrices de l'ombre: "La réappropriation identitaire des femmes latino-américaines sans-papiers".* (Docteur en Lettres), Université de Fribourg (Suisse), Fribourg.

Carbajal, M. (2007). Quand ce n'est pas le moment: les interruptions de grossesse chez les femmes latino-américaines. In i. édition (Ed.), *La Suisse au rythme Latino* (pp. 247-275). Genève.

Carbajal, M., & Pasquier, N. (2006). Migration et Intimité: Amélioration de l'information et de l'accessibilité à la contraception auprès des migrant-e-s. Lausanne: Profa.

Carbajal, M., Pasquier, N., & Cand, J. (2008). Migration & Intimité. Bilan 2006-2008 (pp. 2-14). Canton de Vaud: Fondation Profa et Point Fixe.

Carey, J. W. (1993). Linking Qualitative and Quantitative Methods: Integrating Cultural Factors Into Public Health. *Qualitative Health Research, 3*(3), 298-318.

Carrillo, J. E., Green, A., & Betancourt, J. R. (1999). Cross-cultural primary care: a patient-based approach. *Annals of Internal Medicine, 130*(10), 829-834.

Cattell, R. B. (1966). The Scree Test for the Number of Factors. *Multivariate Behavioral Research, 1*, 245-276.

Chapot, F., Medico, D., & Volkmar, E. (2009). Qui sont les "brésiliennes" à Lausanne? *Agnodice,* 8-17.

Chavez, L. R. (2012). Undocumented immigrants and their use of medical services in Orange County, California. *Social Science and Medicine, 74*, 887-893.

Coleman, D. (2000). The Therapeutic Alliance in Multicultural Practice. *Psychoanalytic Social Work, 7*(2), 65-87.

Confédération-suisse. (2013). Loi fédérale sur l'assurance maladie Retrieved January 10th, 2013, from **http://www.admin.ch/ch/f/rs/832_10/a1a.html**

Corboz-Warnery, A., & Fivaz-Depeursinge, É. (2001). Du couple à la famille: l'alliance parentale prénatale annonce-t-elle le devenir de la famille? *Cahiers critiques de thérapie familiale et de pratiques de réseaux*(2), 17-34.

Creswell, J., & Plano Clark, L. (2007). *Designing and Conducting Mixed Methods Research*. USA: SAGE.

Dasen, P. R. (2002). Introduction. Approches interculturelles: acquis et controverses. *Raisons éducatives*, 7-28.

David, R. A., & Rhee, M. (1998). The Impact of Language as a Barrier to Effective Health Care in an Underserved Urban Hispanic Community. *PubMed: US National Library of Medicine 65*(5&6), 393-397.

Davies, P. (2006). Exploratory research. *The SAGE Dictionary of Social Research Methods* Retrieved March 5th, 2013, from **http://srmo.sagepub.com/view/the-sage-dictionary-of-social-research-methods/n75.xml**

de Roten, Y. (2008). Tout le monde sait que c'est la relation qui compte et pas la technique! *Pratiques en santé mentale*(3), 11-15.

de Roten, Y., Darwish, J., Stern, D., Fivaz-Depeursinge, E., & Corboz-Warnery, A. (1999). Nonverbal communication and alliance in therapy: The body formation coding system. *Journal of clinical psychology, 55*(4), 425-438.

de Roten, Y., Fischer, M., Drapeau, M., Beretta, V., Kramer, U., Favre, N., & Despland, J.-N. (2004). Is One Assessment Enough? Patterns of Helping Alliance Development and Outcome. *Clinical Psychology and Psychotherapy, 11*, 324-331.

de Roten, Y., Fivaz-Depeursinge, E., Stern, D., Darwish, J., & Corboz-Warnery, A. (2000). Body and gaze formations and the communicational alliance in couple-therapist triads. *Psychotherapy Research, 10*(1), 30-46.

DelVecchio Good, M.-J., & Good, B. (1999). Contemporary Doctor-Patient Relationships. In G. L. Albrecht, R. Fitzpatrick & S. Scrimshaw (Eds.), *The Handbook of Social Studies in Health and Medicine* (pp. 243). London: SAGE.

Département de Gynécologie Obstétrique/Planning Familial. (2008). Présentation, Mission, Services du DGO Retrieved August 21, 2008, from **http://www.chuv.ch/dgo/dgo_home.htm**

Despland, J.-N., De Roten, Y., Martinez, E., Plancherel, A., & Solai, S. (2000). L'alliance therapeutique: un concept empirique. *Médecine et hygiène*(2315), 1877-1879.

Despland, J.-N., de Roten, Y., & Stigler, Y. (2003). La contruction de l'alliance thérapeutique. Lausanne: Département Universitaire de Psychiatrie Adulte. Hospice Cantonaux/Etat de Vaud.

Devereux, G. (1956). Normal and abnormal: the key problem of psychiatric anthropology. In J. B. Casagrande & T. Gladwin (Eds.), *Some uses of anthropology: theoretical and applied*. Washington: Anthropology Society of Washington.

Devereux, G. (1977). *Essais d'ethnopsychiatrie générale*. Paris: Gallimard.

Diamond, L. C., Tuot, D., & Karliner, L. (2011). The Use of Spanish Language Skills by Physicians and Nurses: Policy Implications for Teaching and Testing. *J Gen Intern Med, 27*(1), 117-123.

Duncan, B., & Miller, S. (2000). The Client's Theory of Change: Consulting the Client in the Integrative Process. *Journal of Psychotherapy Integration, 10*(2), 169-187.

Dunkle, J. H., & Friedlander, M. L. (1996). Contribution of therapist experience and personal characteristics to the working alliance. *Journal of Counseling Psychology, 43*(4), 456-460.

Elderkin-Thompson, V., Cohen Silver, R., & Waitzkin, H. (2001). When nurses double as interpreters: a study of Spanish-speaking patients in a US primary care setting. *Social Science and Medicine, 52*, 1343-1358.

Elghezouani, A. (2004). *The Critical Link: Professionalisation of Interpreting in the community*. Paper presented at the 4th International Conference on Interpreting in Legal, Health and Social Service Setting, Stockholm. Sweden.

Elghezouani, A. (2010). Modélisation des pratiques psychothérapeutiques avec des migrants allophones. *Psychothérapies, 30*(1), 15-24.

Elghezouani, A., de Roten, Y., Madera, A., & Boss-Prieto, O. L. (2007). Analyse de l'alliance thérapeutique dans la psychothérapie interculturelle: une approche interactionniste. In U. d. L. Institut de Psychologie (Ed.), *Actualités Psychologiques* (Vol. 19). Lausanne.

Eliott, S. (1998). Moving experiences: a qualitative analysis of health and migration. *Health and Place, 4*(4), 327-339.

Es-Safi, L. (2000). Médiation interculturelle dans les hôpitaux (pp. 27-34). Bruxelles: Ministère des Affaires sociales de la Santé publique et de l'environnement.

Eytan, A., Bischoff, A., & Loutan, L. (1999). Use of Interpreters in Switzerland's Psychiatric Services. *The Journal of Nervous and Mental Disease, 187*(3), 190-192.

Faucherre, F., Weber, O., Singy, P., Guex, P., & Stiefel, F. (2010). L'interprète communautaire: une pièce centrale dans le puzzle de la consultation interculturelle. *Revue Médicale Suisse, 6*, 336-338.

Favez, N., & Frascarolo, F. (2011). Le développement des interactions triadiques mère-père-enfant. *Devenir, 23*(4), 359-377.

Fibbi, R., & Meyer, J. B. (2002). *Diasporas, développements et mondialisations*: Editions d l'Aube.

Field, A. (2009). *Discovering Statistics Using SPSS* (Vol. Third Edition): SAGE.

Findlay, A. M. (2005). An auto-biographical approach to understanding migration: the case of Hong Kong emigrants. *Royal Geographical Society, 29*(1), 34-44.

Fleischer, I. (2002). *La consultation de patients migrants chez le médecin praticien avec ou sans traducteur.* (Docteur en Médicine), L'Université de Lausanne, Lausanne.

Fleury, F., & Fierro, I. (2009). La médiation linguistique et culturelle, une nécessité? Lausanne: Appartenances.

Flick, U. (2007). *Managing Quality in Qualitative Research*. London: SAGE.

Florsheim, P., Shotorbani, S., Guest-Warnick, G., Barratt, T., & Hwang, W.-C. (2000). Role of the working alliance in the treatment of delinquent boys in community-based programs. *Journal of clinical child psychology, 29*(1), 94-107.

Forrester, M. A. (2010). *Doing qualitative research in psychology: A practical guide*. Los Angeles, London, New Delhi, Singapore, Washington DC: SAGE Publications Limited.

Foundation, W. (2013). Cross-cultural, from **http://en.wikipedia.org/wiki/Cross-cultural**

Friedlander, M., Horvath, A. O., Cabrero, A., Escudero, V., Heatherington, L., & Martens, M. (2006). System for Observing Family Therapy Alliances: A Tool for Research and Practice. *Journal of Counseling Psychology, 53*(2), 214-224.

Fuertes, J. N., Mislowack, A., Bennett, J., Paul, L., Gilbert, T. C., Fontan, G., & Boylan, L. S. (2007). The physician-patient working alliance. *Patient Education and Counseling, 66*, 29-36.

Fuertes, J. N., Stracuzzi, T. I., Bennett, J., Scheinholt, J., Mislowack, A., Hersh, M., & Cheng, D. (2006). Therapist Multicultural Competency: A Study of Therapy Dyads. *Psychotherapy: Theory, Research and Practice, 43*(4), 480-490.

Galanti, G.-A. (2008). *Caring for patients from different cultures*. Philadelphia: University of Pennsylvania Press.

Gaston, L. (1990). The Concept of the Alliance and its Role in Psychotherapy: Theoritical and empiral considerations. *Psychotherapy 27*, 143-153.

Gaulejac, V. (2009). *Qui est "je"?* Paris: Seuil.

Gehri, M., Hunziker, B., Géraud, F., Rouffaer, D., Sopa, S., Sage-Da Cruz, C., & Métraux, J. (1999). Les populations migrantes à l'Hôpital de l'Enfance de Lausanne (HEL): état des lieux, prise en charge et apport des traducteurs-médiateurs culturels. *Sozial-und Präventivmedizin, 44*, 264-271.

Girard, V., Driffin, K., Musso, S., Naudin, J., Rowe, M., Davidson, L., & Lovell, A. (2006). La relation thérapeutique sans le savoir. Approche anthropologique de la rencontre entre travailleurs pairs et personnes sans chez-soi ayant une co-occurence psychiatrique. *L'évolution psychiatrique, 71*, 75-85.

GmbH, I. T. (2013). A history of Interpreting Retrieved April 15th, 2013, from **http://www.adhoc.at/en/interpreters/a-history-of-interpreting.html**

Goguikian Ratcliff, B. (2010). Du bon usage de l'interprète, entre neutralité et implication émotionnelle. In P. Singy, C. Bourquin & O. Weber (Eds.), *Language barriers in clinical settings* (Vol. 28, pp. 39-56). Lausanne: Cahiers de l'ILSL.

Goguikian Ratcliff, B., & Bercher, D. (2011). Migrants et réfugiés en consultation. *Psychoscope, 9*.

Goguikian Ratcliff, B., & Changkakoti, N. (2004). Le rôle de l'interprète dans la construction de l'intercularité. *L'autre, cliniques, cultures et sociétés, 5*(2), 255-264.

Goguikian Ratcliff, B., & Suardi, F. (2006). L'interprète dans une consultation thérapeutique: conceptions de son rôle et difficultés éprouvées. *Médicine et Hygiène, 26*(1), 37-49.

Golafshani, N. (2003). Understanding Reliability and Validity in Qualitative Research. *The Qualitative Report, 8*(4), 597-607.

Gomez, J. D. (2005). La Emigración Latinoamericana: Contexto Global y Asentamiento en España. *Acciones e Investigaciones Sociales, 21*, 157-184.

Gonzalez Castro, F., & Coe, K. (2007). Traditions and Alcohol Use: A Mixed-Methods Analysis. *Cultural Diversity and Ethnic Minority Psychology, 13*(4), 269-284.

Good, B. (1994). *Medicine, rationality, and experience*. New York: Lewis Morgan Lectures.

Graz, B., Vader, J.-P., & Raynault, M.-F. (2002). Réfugiés, migrants, barrière de la langue: opinion des practiciens sur les moyens d'aide à la traduction. *Santé Publique, 14*(1), 75-81.

Gruen, R., Campbell, E. G., & Blumenthal, D. (2006). Public roles of US physicians. *JAMA: the journal of the American Medical Association, 296*(20), 2467-2475.

Gruen, R., Pearson, S. D., & Brennan, T. A. (2004). Physician-citizens—public roles and professional obligations. *JAMA: the journal of the American Medical Association, 291*(1), 94-98.

Guttfreund, D. G. (1990). Effects of Language Usage on the Emotional Experience of Spanish-English and English-Spanish Bilinguals. *Journal of Consulting and Clinical Psychology, 58*(5), 604-607.

Helman, C. G. (2001). *Culture, health and illness*. London: Arnold Headline Group.

Hemlin, I. (2011). *Interprétation au milieu social*. Paper presented at the Interprétation en milieu social dans les pays francophones, Séville, Espagne.

Hersoug, A. G., Monsen, J. T., Havik, O. E., & Høglend, P. (2002). Quality of early working alliance in psychotherapy: Diagnoses, relationship and intrapsychic variables as predictors. *Psychotherapy and Psychosomatics, 71*(1), 18-27.

Horvath, A. O., & Bedi, R. P. (2002). *The alliance*. New York: Oxford University Press.

Horvath, A. O., & Greenberg, L. S. (1989). Development and Validation of the Working Alliance Inventory. *Journal of Counseling Psychology, 36*(2), 223-233.

Horvath, A. O., & Luborsky, L. (1993). The Role of the Therapeutic Alliance in Psychotherapy. *Journal of Consulting and Clinical Psychology, 61*(4), 561-573.

Hsieh, E. (2006). Understanding Medical Interpreters: Reconceptualizing Bilingual Health Communication. *Health Communication, 20*(2), 177-186.

Hsieh, E., & Jung Hong, S. (2010). Not all are desired: Provider's views on interpreter's emotional support for patients. *Patient Education and Counseling, 81*(2), 192-197.

Hsieh, E., Pitaloka, D., & Johnson, A. (2012). Bilingual Health Communication: Distinctive Needs of Providers from Five Specialties. *Health Communication*, 1-11.

Hudelson, P., & Vilpert, S. (2009). Overcoming language barriers with foreign-language speaking patients: a survey to investigate intra-hospital variation in attitudes and practices. *BCM Health Services Research, 9*(187), 1-9.

Institut Universitaire, d. P. (2012). Unité de recherche du Centre d'étude de la famille Retrieved April 18th, 2013, from **http://www.chuv.ch/pediatrie/dpc_home/dpc_infos/dpc_infos_organisation/dpc_iup/dpc_iup_ur-cef.htm**

Interprèt. (2011a). Association Suisse pour l'interprétariat communautaire et la médiation culturelle. *Définition des activités*, July 2011, from **http://www.inter-pret.ch/fr/linterpretariat-communautaire.html**

Interprèt. (2011b). Le trialogue Santé. In Interprèt (Ed.). Bern, Suisse.

Interprèt. (2012). Formation, certification et assurance qualité Retrieved January 11th, 2013, from **http://www.inter-pret.ch/fr/formation-certification-et-assurance-qualite.html**

Jahoda, G. (2012). Critical reflections on some recent definitions of "culture". *Culture & Psychology, 18*(3), 289-303.

Junod, A., Papeta, D., Ballereau, J., & Moutet. (1991). La Relation Thérapeutique en situation transculturelle. *Médicine d'Afrique Noire, 38*(1).

Kahn, D. (1991). Medication consultation and split treatment during psychotherapy. *Journal of the American Academy of Psychoanalysis*.

Kanninen, K., Salo, J., & Punamäki, R. (2000). Attachment patterns and working alliance in trauma therapy for victims of political violence. *Psychotherapy Research, 10*(4), 435-449.

Kerbrat-Orecchioni, C., & Plantin, C. (1995). *Le trilogue*. Lyon: URA.

Kilani, M. (1992). *Introduction à l'anthropologie*. France: Editions Payot.

King Keenan, E., Tat Tsang, K., Bogo, M., & George, U. (2005). Micro Ruptures and Repairs in the Beginning Phase of Cross-Cultural Psychotherapy. *Clinical Social Work Journal, 33*(3), 271-289.

Kopinak, J. (1999). The Use of Traingulation in a Study of Refugee Well-Being. *Quality and Quantity, 33*, 169-183.

Kramer, U., de Roten, Y., Beretta, V., Michel, L., & Despland, J.-N. (2008). Patient's and therapist's views of early alliance building in dynamic psychotherapy: Patterns and relation to outcome. *Journal of Counseling Psychology, 55*(1), 89.

Kuenzli, F. (2012). Evaluation des psychothérapies. *Hypnose & Therapies Breves*, 40-52.

La Roche, M. J. (2002). Psychotherapeutic Considerations in Treating Latinos. *Harvard Revue of Psychiatry, 10*, 115-122.

Langer, N. (1999). Culturally competent professionals in therapeutic alliances enchance patient compliance. *Journal of Health Care for the Poor & Underserved, 10*(1), 19-26.

Larson, E. B., & Yao, X. (2005). Clinical empathy as emotional labor in the patient-physician relationship. *JAMA: the Journal of the American Medical Association, 293*(9), 1100-1106.

Leanza, Y. (1998). Patients migrants et professionnels de la santé: les enjeux d'une relation interculturelle. *Interdialogos, 2*, 12-16.

Leanza, Y. (2005). Roles of Community Interpreters in pediatrics as seen by interpreters, physicians and researchers. *Interpreting, 7*(2), 167-192.

Leanza, Y. (2006). L'interprète médiateur communautaire: entre ambiguïté et polyvalence. *Revue l'autre, 7*(1), 109-123.

Leanza, Y. (2008). Community Interpreter's Power. The Hazards of a Disturbing Attribute. *Curare. Journal of Medical Anthropology, 31*, 211-220.

Leanza, Y. (2010a). Interpreters in Medical Settings. *Transcultural Psychiatry, 47*(2), 335-349.

Leanza, Y. (2010b). *Représentations et pratiques des professionnels.* Paper presented at the "Communiquer avec les patients migrants: questions d'interprétariat communautaire", Lausanne, Switzerland.

Leanza, Y., Boivin, I., & Rosenberg, E. (2010). Interruptions and resistance: A comparison of medical consultations with family and trained interpreters. *Social Science and Medicine, 70*, 1888-1895.

Leanza, Y., & Klein, P. (2002). Professionnels de la santé et de la relation d'aide en situation interculturelle: quelle formation? *Raisons éducatives*, 281-298.

Leanza, Y., Ogay, T., Perregaux, C., & Dasen, P. (2001). L'intégration en Suisse: un cas particulier *Migrations et Integrations. Regards pluridisciplinaires.* (pp. 17-41). Paris: L'Harmattan.

Lévy, K., & Sturm, G. (2002). Tissage de l'alliance thérapeutique en consultation transculturelle: quelques fils. *Champ psychosomatique, 1*(25), 57-68.

Libertad, M. A., & Grau Abalo, J. A. (2004). La Investigación de la Adherencia Terapéutica como un Problema de la Psicología de la Salud. *Psicología y Salud, 14*(001), 89-99.

Lingiardi, V., Filippucci, L., & Baiocco, R. (2005). Therapeutic alliance evaluation in personality disorders psychotherapy. *Psychotherapy Research, 15*(1-2), 45-53.

Luborsky, L. (1976). Helping Alliances in Psychotherapy: The grounded work for a study of their relationship to its outcome. In J. L. Claghorn (Ed.), *Successful Psychotherapy* (pp. 92-116). New York: Brunner & Mazel.

Luborsky, L. (1994). Therapeutic alliances as predictors of psychotherapy outcomes: Factors explaining the predictive success. In I. B. Weiner (Ed.), *The working alliance: Theory, research, and practice* (pp. 38-50). Canada: Horvath, A.O; Greenberg, L.S.

Luborsky, L. (2000). A Pattern-Setting Therapeutic Alliance Study Revised. *Psychotherapy Research, 10* (1), 17-29.

Lüsebrink, H. (1998). Les concepts de "Culture" et d'"Interculturalité". Approches de définitions et enjeux pour la recherche en communication interculturelle. *Bulletin no. 30*.

Mahoney, J., & Goertz, G. (2004). The Possibility Principle: Choosing Negative Cases in Comparative Research. *American Political Science Review, 98*(4), 653-669.

Malheiros-Poulet, M. E. (1995). Le rôle de l'intermédiare linguistique dans les situations de contacts interculturels *Le trilogue*. Lyon: URA.

Martin, D. J., Garske, J. P., & Davis, M. K. (2000). Relations of the Therapeutic Alliance with Outcome and other Variables: A Meta-Analytic Review. *Journal of Consulting and Clinical Psychology, 68*(3), 438-450.

Mauksch, L. B., Dugdale, D. C., Dodson, S., & Epstein, R. (2008). Relationship, communication, and efficiency in the medical encounter: creating a clinical model from a literature review. *Archives of Internal Medicine, 168*(13), 1387.

Mays, N., & Pope, C. (2000). Qualitative research in health care: assessing quality in qualitative research. *British Medical Journal, 320*, 50-52.

Métraux, J. (2002). L'interprète, ce nouvel acteur. *Cahiers Psychiatriques, 29*, 115-135.

Métraux, J. (2011). *La migration comme métaphore*. Paris: La Dispute.

Métraux, J., & Alvir, S. (1995). L'interprète: traducteur, médiateur culturel ou co-thérapeute. *Interdialogos, 2(22)*, 22-26.

Métraux, J., Weber, O., Singy, P., & Guex, P. (2003). Introduction- Les migrants et le système de soins helvétique. In E. M. Hygiène (Ed.), *Quand la médecine a besoin d'interprètes* (pp. 11-35). Genève: Cahiers Medico-Sociaux.

Meyer, J. B., & Wattiaux, J.-P. (2006). Diaspora knowledge networks: vanishing doubts and increasing evidence. *International Journal on Multicultural Societies, 8*(1), 4-24.

Miller, K., Martell, Z., Pazdireck, L., Caruth, M., & Lopez, D. (2005). The Role of Interpreters in Psychotherapy with Refugees: An Exploratory Study. *American Journal of Orthopsychiatry, 75*(1), 27-39.

Miller, S. (2009). *Pathways to Possibilities: What Works with the "Resistant", "Unmotivated", or Mandated Person in Therapy*, Workshop, Switzerland.

Montaluisa Vivas, R. (2007). L'émigration équatorienne: ses causes et ses conséquences. In i. éditions (Ed.), *La Suisse au rythme latino* (pp. 93-114). Genève.

Moro, M. R. (1994). *Parents en exil. Psychopathologie et migrations*: PUF.

Moro, M. R., de La Noë, Q., & Mouchenik, Y. (2004). *Manuel de psychiatrie transculturelle: travail clinique, travail social*: La Pensée Sauvage.
Murdock, G. P. (1957). World Ethnographic Sample. *American Anthropologist 59*(4), 664-687.
Nagel, J. (1994). Constructing Ethnicity: Creating and Recreating Ethnic Identity and Culture. *Social Problems, 41*(1), 152-176.
Nathan, T. (1986). *La folie des autres. Traité d'ethnopsychiatrie clinique*. Paris: Dunod.
Navia, C. E., & Arias, E. M. (2010). Alianza terapéutica y su relación con las variables de apego del terapeuta y del consultante. *Universitas Psychologica, 11*(3), 885-894.
OFS. (2010). Population résidante permanente et non permanente étrangère selon la nationalité par pays et le sexe: Office féderale de la statistique (Suisse).
OFS. (2011). Population Etrangère en Suisse. Bern: Office féderale de la statistique (Suisse).
OFSP. (2011). Des ponts linguistiques pour mieux guérir. Berne: Office fédérale de la santé publique.
OIM. (2010a). Informe sobre las Migraciones en el Mundo 2010: Organización Internacional para Las Migraciones.
OIM. (2010b). Termes clés de la migration Retrieved August 30, 2011, from **http://www.iom.int/jahia/Jahia/about-migration/key-migration-terms/lang/fr - Migrant**
Ortiz, F. (1940). Del fenómeno social de la "transculturación" y de su importancia en Cuba. *Revista Bimestre Cubana, 46*(273-278).
Paillé, P., & Mucchielli, A. (2008). *L'analyse qualitative en sciences humaines et sociales*. Paris: A. Colin.
Palomino, M. A. (2004). Latino Immigration in Europe: Challenge and Opportunity for Mission. *International Bulletin of Missionary Research, 28*(2).
Paris, M., Añez, L. M., Bedregal, L. E., Andrés-Hyman, R. C., & Davidson, L. (2005). Help seeking and satisfaction among Latinas: The roles of setting, ethnic identity, and therapeutic alliance. *Journal of Community Psychology, 33*(3), 299-312.
Piller, I. (2000). Language choice in bilingual, cross-cultural interpersonal communication. *Linguistik online, 5*(1), 1-20.
Piller, I. (2011). *Intercultural communication: A critical introduction*: Edinburgh University Press Edinburgh.
Polaschek, D., & Ross, E. (2010). Do early therapeutic alliance, motivation, and stages of change predict therapy change for high-risk, psychopathic violent prisoners? *Criminal Behaviour and Mental Health, 20*, 100-111.
Posada Saldarriaga, R. (2009). Hermenéutica y Medicina. *Revista CES Medicina, 23*(1), 103-113.
PROFA. (2007). Présentation et Services de PROFA Retrieved October 30, 2008, from **http://www.profa.ch/Accueil/accueil.htm**
Raval, H., & Maltby, M. (2005). Not getting lost in translation: establishing a working alliance with co-workers and interpreters. In C. Flaskas, B. Mason & A. Perlesz (Eds.), *The space between experience, context and process in the therapeutic relaitonship* (pp. 63-78). London: Karnac Books.

Renteria, S.-C. (2003). Analyse du point de vue des patients. In E. M. Hygiène (Ed.), *Quand la médecine a besoins d'interprètes* (pp. 59-84). Genève: Cahiers médico-sociaux.

Revelle, W., & Zinbarg, R. (2009). Coefficients alpha, beta, omega and the glb: comments on Sijtsma. *Psychometrika, 74*(1), 145-154.

Riaño, Y. (2003). Migration of skilled Latin American women to Switzerland and their struggle for integration. In M. Yamada (Ed.), *Population Movement in the Modern World* (pp. 313-343). Osaka: The Japan Centre for Area Studies, National Museum of Ethnology.

Rieben, I. (2012). *Qualité de l'attachment dans la psychose et figures spirituelles.* (Docteur en psychologie), Université de Lausanne, Lausanne.

Rodondi, P.-Y., Guex, P., & Vannotti, M. (2005). Que cache l'agenda caché? *La Revue Médical Suisse, 1*(5), 365-368.

Rogers, N., Lubman, D. I., & Allen, N. B. (2008). Therapeutic alliance and change in psychiatric symptoms in adolescents and young adults receiving drug treatment. *Journal of Substance Use, 13*(5), 325-339.

Rohner, R. (1984). Toward a conception of culture for cross-cultural psychology. *Journal of Cross-cultural psychology, 15*(2), 111-138.

Ronsenbaum, F. (2003). *Le passeur de parole entre les soignants et la famille migrante: une façon de tisser le lien thérapeutique.* Paper presented at the Identité-Filiation-Langage, Bordeaux, France.

Rosado, C. (1996). *Toward a Definition of Multiculturalism*. Rosado Consulting.

Rosado, J. W., & Elias, M. J. (1993). Ecological and Psychocultural Mediators in the Delivery of Services for Urban, Culturally Diverse Hispanic Clients. *Professional Psychology: Research and Practice, 24*(4), 450-459.

Rosenberg, E., Leanza, Y., & Seller, R. (2007). Doctor-patient communication in primary care with an interpreter: Physician perceptions of professional and family interpreters. *Patient Education and Counseling, 67*, 286-292.

Rosenberg, E., Seller, R., & Leanza, Y. (2007). Through interpreters' eyes: Comparing roles of professional and family interpreters. *Patient Education and Counseling, 70*, 87-93.

Rossi, I. (1999). Médiation culturelle et formation des professionnels de la santé- de l'interculturalité à la co-disciplinarité. *Sozial- und Präventivmedizin, 44*, 288-294.

Rossi, I. (2002). Réseaux de soins, réseaux de santé. *Tsantsa*(7), 12-20.

Rossi, I. (2003). Mondialistaion et sociétés plurielles ou comment penser la relation entre santé et migration. *Médicine&Hygiène, 59*(2455), 2039-2042.

Rossi, I. (2008). Médicalisation du mal-être, migration et société. *Revue des Sciences Sociales*(39), 54-63.

Rothenbühler, I., Burkhard, M., & Rothenbühler, N. (2007). Le rôle de l'Espace-Hommes auprès des migrants d'Amérique latine. In i. éditions (Ed.), *La Suisse au rythme latino* (pp. 289-303). Genève.

Safran, J., & Muran, C. (Eds.). (2005). *La Alianza Terapeutica*. Cantabria, España: Desclée de Brouwer.

Saldaña, J. (2009). *The Coding Manual for Qualitative Researchers*: SAGE Publications.

Sangra Bron, I. (2006). Femmes latino-américaines "sans papiers": réflexion sur l'isolement *Mémoire CAS*. Lausanne: Université de Lausanne, Haute Ecole de travail social et de la santé et Haute école de la santé la Source.

Santiago-Delefosse, M. (2004). Évaluer la qualité des publications: Quelles spécificités pour la recherche qualitative? *Pratiques psychologiques, 10*(3), 243-254.

Santiago-Delefosse, M. (2006). La tension entre théorie et terrain. In P. Paillé (Ed.), *La méthodologie qualitative: postures de recherche et travail de terrain* (pp. 201-223). Paris: A. Colin.

Santiago-Delefosse, M. (2010). Développement des courants "critiques" dans la psychologie anglo-saxonne: A propos de la santé somatique et/ou mentale. *Féderer: le Bulletin des Pychologues et de la Psychologie, 2*, 5-6.

Santiago-Delefosse, M., & Rouan, G. (2001). *Les méthodes qualitatives en psychologie*. Paris: Dunod.

Satterfield, W. A., & Lyddon, W. J. (1998). Client attachment and the working alliance. *Counselling Psychology Quarterly, 11*(4), 407-415.

Sayokan, J., Musso, S., & Mulot, S. (2011). Quand la santé et les médecines circulent. *Anthropologie et santé, 3*, 2-12.

Seale, C., & Silverman, D. (1997). Ensuring rigour in qualitative research. *The European Journal of Public Health*(7), 379-384.

Sexton, H. C., Hembre, K., & Kvarme, G. (1996). The interaction of the alliance and therapy microprocess: A sequential analysis. *Journal of Consulting and Clinical Psychology, 64*(3), 471.

Shonfeld-Ringel, S. (2001). A Re-conceptualization of the Working Alliance in Cross-Cultural Practice with Non-Western Clients: Integrating Relational Perspectives and Multicultural theories. *Clinical Social Work Journal, 29*(1), 53-63.

Singy, P., & Guex, P. (2005). The interpreter's roles with immigrants patients: Contrasted points of view. *Communication & Medicine, 2*(1), 45-51.

Singy, P., & Weber, O. (2001). L'interprète dans la relation médecin-patient migrant: une présence discutée. *Médicine et Hygiène, 59*, 312-315.

Slobin, D. I. (1996). From "thought and language" to "thinking for speaking" *Rethinking linguistic relativity* (pp. 70-96). Colorado.

Staab, S. (2003). *En búsqueda de trabajo. Migración internacional de las mujeres latinoamericanas y caribeñas: Bilbiografía seleccionada*. Santiago de Chile: Mujer y Desarrollo.

Stienen, S. (2003). Nuevas Dinamicas Urbanas y Estrategias de Integración de Migrantes Andinos Indocumentados en Suiza. *Economía, Sociedad y Territorio, IV*(13), 27-62.

Takeuchi, D. T., Sue, S., & Yeh, M. (1995). Return rates and outcomes from ethnicity-specific mental health programs in Los Angeles. *American Journal of Public Health, 85*(5), 638-643.

Teutsch, C. (2003). Patient-doctor communication. *The Medical Clinic of North America, 87*, 1115-1145.

Thompson, C. (2003). *Client's Perception of the Therapeutic Relationship and its Role in Outcome.* (Master of Education), University of Lethbridge, Lethbridge, Alberta (USA).

Triandis, H., Vassiliou, V., Vassiliou, G., Tanaka, Y., & Shanmugam, A. (1972). *The analysis of subjective culture*: Wiley-Interscience New York.

Tribe, R. (1999). Bridging the gap or damming the flow? Some observations on using interpreters-bilingual workers when working with refugee clients, many of whom have been tortured. *British Journal of Medical Psychology, 72*, 567-576.

Tribe, R., & Morrissey, J. (2003). The Refugee Context and the Role of Interpreters. In R. Tribe & H. Raval (Eds.), *Working with Interpreters in Mental Health* (pp. 198-218). USA and Canada: Brunner-Routledge.

Turra, C. M., & Elo, I. T. (2008). The Impact of Salmon Bias on the Hispanic Mortality Advantage: New Evidence from Social Security Data. *Springer Science+Business Media, 27*, 515-530.

Uribe, G. (2012). La population latino-américaine en Espagne: nouvelles diasporas, nouvelles mobilités. *Revue européenne des migrations internationales, 28*(1), 169-178.

Valero Garcés, C. (2005). Doctor-patient consultations in dyadic and triadic exchanges. *Interpreting, 7*(2), 193-210.

Valli, M. (2003). Les migrants sans permis de séjour à Lausanne. Lausanne: Rapport rédigé à la demande de la Municipalité de Lausanne.

Valli, M. (2007). Les Latino-Américains sans-papiers à Lausanne: l'insertion cachée. In i. éditions (Ed.), *La Suisse au rythme latino* (pp. 185-197). Genève.

Veloski, J., Tai, S., Evans, A. S., & Nash, D. B. (2005). Clinical vignette-based surveys: a tool for assessing physician practice variation. *American Journal of Medical Quality, 20*(3), 151-157.

Wagley, C., & Harris, M. (1955). A typology of Latin American subcultures. *American Anthropologist, 57*(3), 428-451.

Ward, M. R. (2000). *Client's Perception of the Therapeutic Process: A Common Factors Approach.* (Masters of Science in Human Development), Virginia Polytechnic Institute and State University, Virginia, USA.

Wassermann, D. (2012). *Migration and Mental Health*. Paper presented at the 1st European Congress for Social Psychiatry, Geneva.

Weber, O. (2003). Le discours des soignants sur les consultations impliquant des migrants. In P. Guex & P. Singy (Eds.), *Quand la médecine a besoin d'interprètes* (pp. 113-139). Genève: Médecine & Hygiène

Wihtol de Wenden, C. (2007). The frontiers of mobility. In A. Pécoud & P. Guchteneire (Eds.), *Migration without borders*: UNESCO Publishing.

Wihtol de Wenden, C. (2010). *La question migratoire au XXIe siècle*. Paris: SciencesPo. Les Presses.

Wolff, H., Stalder, H., Epiney, M., Walder, A., Irion, O., & Morabia, A. (2005). Health Care and illegality: a survey of undocumented pregnant immigrants in Geneva. *Social Science and Medicine, 60*, 2149-2154.

ANNEXES

Annex A: Questionnaire QALM-PS (Patients)

Si usted consulta en pareja o en familia, gracias por escribir los datos personales de cada uno de sus miembros sobre la misma línea, separados por un punto y coma (;).

Sexo: _____ Edad:_____ País de Origen: _____
Tiempo de residencia en Suiza: _____
Status en Suiza (ex: permiso, nacionalidad, clandestinidad, etc.): _____
Desde hace cuanto tiempo (días, semanas, meses o años) usted consulta en esta institución?_____
Aproximadamente, hoy es la _____ (1ª,2ª etc.) vez que encuentro este mismo terapeuta o profesional de la salud.
Si su terapeuta habla Español, gracias por indicar si es su lengua materna y de escribir su país de origen
_____

Cuestionario de La Alianza Terapéutica
para Emigrantes- Profesionales de la Salud
(QALM-PS·*)

Parte I. ***Alianza con el Terapeuta***

Las 19 afirmaciones que se encuentran en la pagina siguiente describen maneras diferentes de pensar y sentirse con relación a su terapeuta.

Terapeuta=profesional de la salud (ex : psicólogo(a), médico(a), partera, asistente social, enfermero(a), etc.)

Piense a la relación actual que tiene ***con su terapeuta*** y marque con una cruz la casilla que corresponda lo mejor posible a su forma de sentir. Hay 5 posibilidades:

1 Jamás
2 Raramente
3 Algunas veces
4 Frecuentemente
5 Siempre

No hay buenas ni malas respuestas. Gracias por marcar una casilla para cada una de las afirmaciones. Sus respuestas son anónimas y confidenciales. Si usted consulta en pareja o en familia, gracias por responder juntos (en lo posible) a un solo cuestionario.

· Versión QALM-PS (juin 2009) © De Roten Y, Madera A, Boss-Prieto O, & Elghezouani A (2007). *Instituto Universitario de Psicoterapia, Asociación Appartenances y Universidad de Lausana*. Traducción en Español : Boss-Prieto O. La versión QALM-PS es una adaptación del QALM versión 1.0 (2007). Le QALM-PS está destinado a la evaluación de la alianza terapéutica en todo tipo de consulta con un profesional de la salud a diferencia del QALM versión 1.0 que es utilizado solamente en una consultación psicológica/psiquiatrica. Versión adaptada por : Boss-Prieto O., Universidad de Lausana.

	Jamás	Raramente	Algunas Veces	Frecuentemente	Siempre
1. Siento que mi terapeuta me respeta	☐1	☐2	☐3	☐4	☐5
2. Estoy seguro(a) que lo que digo a mi terapeuta no sale de aquí	☐1	☐2	☐3	☐4	☐5
3. Aprecio mi terapeuta como persona	☐1	☐2	☐3	☐4	☐5
4. Me siento apoyado(a) por mi terapeuta	☐1	☐2	☐3	☐4	☐5
5. Tengo una buena relación con mi terapeuta	☐1	☐2	☐3	☐4	☐5
6. Sé lo que espero viniendo en consulta	☐1	☐2	☐3	☐4	☐5
7. Tengo la impresión que mi terapeuta me ofrece lo que necesito	☐1	☐2	☐3	☐4	☐5
8. Me siento seguro(a) con mi terapeuta	☐1	☐2	☐3	☐4	☐5
9. Mi terapeuta y yo colaboramos para fijar los objetivos de mi consulta	☐1	☐2	☐3	☐4	☐5
10. Pienso que mi terapeuta me ayuda	☐1	☐2	☐3	☐4	☐5
11. Tengo la impresión de ser aceptado(a) por mi terapeuta	☐1	☐2	☐3	☐4	☐5
12. Creo que mi terapeuta tiene los conocimientos y capacidades para ayudarme	☐1	☐2	☐3	☐4	☐5
13. Creo que la manera de trabajar mis problemas en terapia es correcta	☐1	☐2	☐3	☐4	☐5
14. Me siento cómodo(a) y relajado(a) en la presencia de mi terapeuta	☐1	☐2	☐3	☐4	☐5
15. Me gusta la actitud que mi terapeuta tiene conmigo	☐1	☐2	☐3	☐4	☐5
16. Sé que puedo tener confianza en mi terapeuta	☐1	☐2	☐3	☐4	☐5
17. Siento que mi terapeuta y yo trabajamos en un esfuerzo común para resolver mis problemas	☐1	☐2	☐3	☐4	☐5
18. Mi terapeuta y yo tenemos intercambios productivos	☐1	☐2	☐3	☐4	☐5
19. Siento que mi terapeuta me comprende	☐1	☐2	☐3	☐4	☐5

Parte II. ***Alianza con el Intérprete***

Atención : Si un intérprete esta presente durante su consulta, gracias por completar esta parte. Si no hay ayuda de un intérprete, pase directamente à la parte III en la página 4.

Gracias por indicar el tipo intérprete que esta lo mas frecuentemente presente en su consulta :

☐ Miembro de la familia (cuál: _____)
☐ Amigo o allegado
☐ Interprete profesional
☐ Empleado de la institución que trabaja en un oficio otro que la interpretación (ex : secretaria)

Si posible, gracias por escribir la lengua materna y el país de origen del intérprete: _____

Piense ahora a la relación actual ***con su intérprete*** y marque con una cruz la casilla que corresponda lo mejor posible a su forma de sentir.

	Jamás	**Raramente**	**Algunas Veces**	**Frecuentemente**	**Siempre**
1. Pienso que mi intérprete me ayuda	☐1	☐2	☐3	☐4	☐5
2. Tengo la impresión que mi intérprete me ofrece lo que necesito	☐1	☐2	☐3	☐4	☐5
3. Aprecio mi intérprete como persona	☐1	☐2	☐3	☐4	☐5
4. Creo que mi intérprete tiene los conocimientos y capacidades para ayudarme	☐1	☐2	☐3	☐4	☐5
5. Me siento apoyado(a) por mi intérprete	☐1	☐2	☐3	☐4	☐5
6. Siento que mi intérprete me comprende	☐1	☐2	☐3	☐4	☐5
7. Tengo la impresión que mi intérprete traduce adecuadamente todo lo que se dice en consulta	☐1	☐2	☐3	☐4	☐5
8. Siento que mi intérprete me respeta	☐1	☐2	☐3	☐4	☐5
9. Me gusta la actitud que mi intérprete tiene conmigo	☐1	☐2	☐3	☐4	☐5
10. Estoy seguro(a) que mi intérprete comprende bien todo lo que se dice en consulta	☐1	☐2	☐3	☐4	☐5
11. Pienso que mi consulta sería mas eficaz si yo no necesitara intérprete	☐1	☐2	☐3	☐4	☐5
12. Tengo una buena relación con mi intérprete	☐1	☐2	☐3	☐4	☐5
13. Me siento seguro(a) con mi intérprete	☐1	☐2	☐3	☐4	☐5
14. Estoy seguro(a) que lo que digo a mi intérprete no sale de aquí	☐1	☐2	☐3	☐4	☐5

	Jamás	Raramente	Algunas Veces	Frecuentemente	Siempre
15. Se que puedo tener confianza en mi intérprete	☐1	☐2	☐3	☐4	☐5
16. Siento que mi intérprete y yo trabajamos en un esfuerzo común para resolver mis problemas	☐1	☐2	☐3	☐4	☐5
17. Tengo la impresión de ser aceptado(a) por mi intérprete	☐1	☐2	☐3	☐4	☐5
18. Me siento cómodo(a) y relajado(a) en la presencia de mi intérprete	☐1	☐2	☐3	☐4	☐5
19. Mi interprete y yo tenemos intercambios productivos	☐1	☐2	☐3	☐4	☐5

Parte III. ***Evolución***

Atención : Si usted ha consultado este terapeuta dos veces o mas, gracias por completar esta parte. En caso contrario, usted ha terminado el cuestionario.

Espera usted un cambio psicológico y/o físico con sus consultas?
☐ Si ☐ No
Si su respuesta es afirmativa, gracias por completar esta ultima parte del cuestionario. Sino, ha terminado el cuestionario.

Las 6 afirmaciones siguientes se refieren a los cambios que usted pudo haber sentido en el transcurso de sus consultas. Marque con una cruz la casilla que corresponda lo mejor posible a su forma de sentir.

	Jamás	Raramente	Algunas Veces	Frecuentemente	Siempre
1. Siento que lo que hacemos en consulta me va a ayudar a alcanzar los cambios deseados	☐1	☐2	☐3	☐4	☐5
2. Mis dificultades han disminuido gracias a mis consultas	☐1	☐2	☐3	☐4	☐5
3. Gracias a estas consultas, veo mas claramente cómo podría ser capaz de cambiar/mejorar mi situación	☐1	☐2	☐3	☐4	☐5
4. Lo que hacemos durante las consultas me brinda nuevas maneras de ver/manejar mis problemas	☐1	☐2	☐3	☐4	☐5
5. En general, me siento mejor luego de una consulta	☐1	☐2	☐3	☐4	☐5
6. Los cambios observados en el transcurso de mis consultas corresponden a mis expectativas	☐1	☐2	☐3	☐4	☐5

Ha terminado el cuestionario. Muchas gracias por su apreciada colaboración !

Annex B: Semi-structured interview (Patients)

GUIA DE ENTREVISTA SEMI-ESTRUCTURADA CON LOS PACIENTES

(2nd fase de la investigación)

Terapeuta=profesional de la salud (ex : psicólogo, médico, partera, asistente social, enfermera, etc.)

1. Cómo llego usted à Suiza y cuales son sus proyectos en este proceso migratorio?

2. Cuál es el motivo por el cual usted vino a consultar ?

3. Cuál es el camino que usted siguió para llegar a esta institución?

4. Cuénteme, cómo le va con su terapeuta? (En situación triádica: y con su interprete? Que tipo de interprete tiene en consultación ?)

5. Qué lo/la hace sentir de esta manera ?

6. Cuales son sus criterios para tener una buena relación con su terapeuta? (En situación triádica: y con su interprete?)

7. Podría describir una sesión o una parte de la sesión en la cual usted considera que hubo un buen contacto con su terapeuta (En situación triádica: y con su interprete?)

8. Podría describir una sesión o una parte de la sesión en la cual usted considera que hubo un mal contacto con su terapeuta (En situación triádica: y con su interprete?)

9. Qué lo motiva a seguir en esta terapia/tratamiento, o lo contrario, a dejarla? (En caso de una sola consultación, volvería usted a consultar este mismo profesional y por que?)

10. En situación triádica:
    Ha tenido este mismo intérprete presente en otra situación? Si la respuesta es SI, en que situación y cual cree usted que es la diferencia en el trabajo que él efectúa?

11. Hay algo que le gustaría añadir antes de terminar esta entrevista?

Annex C: Informed Consent (Patients) - Questionnaire

Consentimiento del Paciente (Primera fase: Cuestionario)

UNIL | Université de Lausanne
Instituto de Psicología
1015 Lausannne, Suiza

Olga Lucia BOSS-PRIETO, candidata doctorante
Dirección : Profesor Pascal Roman
Co-dirección : Profesor Ilario Rossi
Garant de l'étude au CHUV : Dr. Mario Gehri, HEL. Privat-docent UNIL

La Alianza Terapéutica Diádica y Triádica en Situación Multicultural: El Caso de los Hispanoamericanos en Suiza

Querido Compatriota Hispanoamericano,

Por medio de este proyecto quiero estudiar la alianza entre el terapeuta (terapeuta=profesional de la salud) y los pacientes Hispanoamericanos. En caso tal que usted reciba ayuda con interprete, también me interesa estudiar la relación con éste. El objetivo de mi estudio es analizar como mejorar el tratamiento des personas provenientes de nuestra cultura a través de la relación con los diferentes profesionales de la salud.

Para esto, es importante de contestar el cuestionario abiertamente, incluyendo los aspectos positivos y negativos en su relación con el terapeuta y con el interprete según el caso.

El contenido del cuestionario es confidencial. Su terapeuta no tendrá acceso a éste. En todo caso, el cuestionario es anónimo, es decir que su nombre no es marcado sobre éste. Si una o varias preguntas le parecen indiscretas o molestas usted tiene la libertad de no responder o de parar el cuestionario en cualquier momento.

Si por algún motivo, usted ha estado en consulta con mas de un profesional en esta misma institución, lo invito a llenar el formulario pensando solamente en uno de ellos o a llenar un formulario por cada profesional si su tiempo lo permite.

En caso tal que el paciente principal sea un niño (0-11 años), el cuestionario seria contestado por el/los padre(s) o el adulto responsable del menor. Por los adolescentes (12-18 años), el cuestionario será contestado por ellos mismos con el acuerdo de el adulto que lo acompaña.

Muchas gracias por su participación!!

Olga Lucia Boss-Prieto
Psicóloga
Universidad de Lausana
Teléfono: 021 692 3259/3260 email: OlgaLucia.Boss-Prieto@unil.ch

Annex C: Informed Consent (Patients) - Questionnaire

Consentimiento del Paciente (Primera fase: Cuestionario)

UNIL | Université de Lausanne
Instituto de Psicología
1015 Lausannne, Suiza

Olga Lucia BOSS-PRIETO, candidata doctorante
Dirección : Profesor Pascal Roman
Co-dirección : Profesor Ilario Rossi
Garant de l'étude au CHUV : Dr. Mario Gehri, HEL. Privat-docent UNIL

La Alianza Terapéutica Diádica y Triádica en Situación Multicultural: El Caso de los Hispanoamericanos en Suiza

Consentimiento Informado

A través de mi firma confirmo que:

- Fui informado(a) sobre los objetivos de este estudio.
- Leí las explicaciones dadas en la carta de información.
- Un tiempo de reflexión me fue dado para dar mi acuerdo de participación.
- Fui informado(a) de mi libertad de no contestar a cualquier pregunta que me parezca inadecuada o de suspender en cualquier momento mi participación.
- Fui informado(a) que mis datos personales serán guardados como anónimos por la investigadora principal.

A través de mi firma confirmo mi acuerdo para contestar el cuestionario.

_____
Lugar y Fecha

_____ _____
Nombre Firma
(Si menor de edad, firma del padre o del adulto que acompaña)

_____ _____
Nombre del investigador Firma

Annex C: Informed Consent (Patients) - Questionnaire

Consentimiento del Paciente (Primera fase: Cuestionario)

UNIL | Université de Lausanne
Instituto de Psicología
1015 Lausannne, Suiza

Olga Lucia BOSS-PRIETO, candidata doctorante

Dirección : Profesor Pascal Roman
Co-dirección : Profesor Ilario Rossi
Garant de l'étude au CHUV : Dr. Mario Gehri, HEL. Privat-docent UNIL

La Alianza Terapéutica Diádica y Triádica en Situación Multicultural: El Caso de los Hispanoamericanos en Suiza

Continuación del Proyecto

La segunda fase de este proyecto consiste en una entrevista corta realizada por mi misma. Su participación es importante pues me permitiría obtener una perspectiva mas profunda acerca de su relación con el terapeuta y el interprete si este ultimo está presente. Esta entrevista sería realizada en el lugar y hora de su y mi conveniencia. Los gastos relativos al transporte (metro, bus) le serán reconocidos si la entrevista no es realizada es su residencia.

Su colaboración es muy apreciada. Sin embargo, si usted esta en desacuerdo de participar a la entrevista, su tratamiento terapéutico no será para nada afectado por su decisión.

Si esta de acuerdo de ser contactado para esta segunda fase, por favor déjeme su nombre y numero de teléfono. Le recuerdo, que estos datos los guardaré de manera confidencial y serán destruidos una vez que este estudio se lleve acabo.

Nombre:
Teléfono: Email (opcional):

Annex C: Informed Consent (Patients) - Interview

Consentimiento del Paciente (Segunda fase Entrevista)

UNIL | Université de Lausanne
Instituto de Psicología
1015 Lausannne, Suiza

Olga Lucia BOSS-PRIETO, candidata doctorante

Dirección : Profesor Pascal Roman
Co-dirección : Profesor Ilario Rossi
Responsable del estudio en el CHUV : Dr. Mario Gehri, HEL, Privat-docent UNIL

La Alianza Terapéutica Diádica y Triádica en Situación Multicultural: El Caso de los Hispanoamericanos en Suiza

Querido Compatriota Hispanoamericano,

Gracias por haber aceptado de participar en la segunda fase de este proyecto que consiste en una entrevista con el objetivo de conocerlo(a) personalmente y obtener su punto de vista mas profundo sobre la calidad de la relación con su terapeuta (terapeuta=profesional de la salud) y con su interprete según el caso.

Esta vez también es importante contestar la entrevista abiertamente, incluyendo los aspectos positivos y negativos en su relación con el terapeuta y con el interprete si esté ultimo está presente.

Con su autorización, la entrevista será grabada por un medio auditivo. La grabación será transcrita y luego destruida. Su contenido es confidencial. Su terapeuta no tendrá acceso a ésta. En todo caso, la entrevista es anónima, es decir que su nombre no es mencionado sobre ésta. Si una o varias preguntas le parecen indiscretas o molestas usted tiene la libertad de no responder o de parar la entrevista en cualquier momento.

Si por algún motivo, usted ha estado en consulta con mas de un profesional en esta misma institución, lo invito a contestar las preguntas pensando solamente en uno de ellos o a contestar una entrevista por cada profesional si su tiempo lo permite.

En caso tal que el paciente principal sea un niño (0-11 años), la participación a la entrevista es efectuada por el/los padre(s) o el adulto responsable del menor. Por los adolescentes (12-18 años), la participación es efectuada por ellos mismos con el acuerdo del adulto que lo acompaña.

Muchas gracias por su participación!!

Olga Lucia Boss-Prieto

Psicóloga
Universidad de Lausana
Teléfono: 021 692 3259/3260 *email: OlgaLucia.Boss-Prieto@unil.ch*

Annex C: Informed Consent (Patients) – Interview

UNIL | Université de Lausanne
Instituto de Psicología
1015 Lausannne, Suiza

Olga Lucia BOSS-PRIETO, candidata doctorante

Dirección : Profesor Pascal Roman
Co-dirección : Profesor Ilario Rossi
Responsable del estudio en el CHUV : Dr. Mario Gehri, HEL, Privat-docent UNIL

La Alianza Terapéutica Diádica y Triádica en Situación Multicultural: El Caso de los Hispanoamericanos en Suiza

Consentimiento Informado

A través de mi firma confirmo que:

- Fui informado(a) sobre los objetivos de este estudio.
- Leí las explicaciones dadas en la carta de información.
- Un tiempo de reflexión me fue dado para dar mi acuerdo de participación.
- Fui informado(a) de mi libertad de no contestar a cualquier pregunta que me parezca inadecuada o de suspender en cualquier momento mi participación.
- Fui informado(a) que mis datos personales serán guardados como anónimos por la investigadora principal.
- Fui informado(a) que la entrevista será grabada de manera anónima. Estoy al tanto que el archivo será trascrito y luego destruido.

A través de mi firma confirmo mi acuerdo para contestar la entrevista grabada.

_____
Lugar y Fecha

_____ _____
Nombre Firma
(Si menor de edad, firma del padre o del adulto que acompaña

_____ _____
Nombre del investigador Firma

Annex D: Informed Consent (Health Professionals)

Projet de thèse de doctorat
Université de Lausanne, Institut de Psychologie
Direction : Professeur Pascal Roman
Co-direction : Professeur Ilario Rossi

Investigateur principal : Olga Lucia Boss-Prieto
Assistante doctorante en Psychologie
OlgaLucia.Boss-Prieto@unil.ch

« L'alliance thérapeutique dyadique et triadique dans un cadre multiculturel: le cas des hispano-américains dans le système de santé Lausannois avec ou sans l'assistance d'un interprète »

CONSENTEMENT ECRIT

L'objectif de cet entretien avec les professionnels de la santé est de mieux connaître leur travail avec les patients hispano-américains dans chaque institution concernée par cette étude.

Selon le consentement, l'entretien sera enregistré sur un support audio pour faciliter le recueil d'information. Cependant, il ne sera pas transcrit. Le contenu de l'entretien peut être utilisé dans le projet pour mieux comprendre la problématique et pour l'analyse de résultats.

Nom du professionnel : Signature :

Institution : Date :

Annex E: Semi-structured Interview (Health Professionals)

ENTRETIEN INITIAL AVEC LES PROFESSIONNELS DE LA SANTE DES SERVICES DE SOINS DANS LE SYSTEME DE SANTE DE LA REGION DE LAUSANNE

(Le système de Santé concerné comprend : L'Association Appartenances, La Policlinique, L'Hôpital de l'Enfance, Le Département de Gynécologie-Obstetrique, PROFA, et Le Point d'Eau)

Type de patients, problématiques

1. Quelles sont les relations entre votre institution et la communauté hispano-américaine ?
2. Pouvez-vous me parler des prises en charge qui s'effectuent et de leurs durées ?
3. Comment arrivent-ils à consulter chez vous? Quel est le parcours qui les emmène dans votre institution?
4. Pourriez-vous identifier des particularités présentes chez les patients hispano-américains en comparaison avec des patients d'autres cultures ?
5. Quels sont leurs motifs de consultation les plus fréquents ?

Suivi ou traitement

6. Quel est leur comportement et leur attitude en consultation en comparaison avec des patients d'autres cultures ?
7. Dans quelles circonstances, les patients hispano-américains se montrent plus observants/compliants? Pouvez-vous donner un exemple ?
8. Dans quelles circonstances, les patients hispano-américains se montrent plus réticents? Pouvez-vous donner un exemple ?
9. Avez-vous rencontré des obstacles en travaillant avec les patients hispano-américains ?
10. Qu'est-ce que vous avez trouvé comme ressources en travaillant avec cette population?

Travail en Dyade ou en Triade

11. Au niveau de la communication avec les patients hispano-américains, sollicitez-vous des interprètes ?
12. Dans quelles situations, vous faites appel aux interprètes ?
13. Sont-ils rémunérés et avec quelles ressources ?
14. Ces interprètes, sont-ils des professionnels formés pour cette activité ?
15. Dans quelles situations vous ne fait pas appel aux interprètes ?
16. Combien de professionnels bilingues sont à disposition de vos patients?
17. Comment percevez-vous le travail à deux et à trois ? Pouvez-vous donner un exemple ?
18. Qu'est-ce que vous pouvez dire de votre lien avec l'interprète(s) ?
19. Quelle est votre appréciation sur l'effet de la présence d'un interprète dans le processus thérapeutique ?

Annex F: Data Sheets (Health Professionals)

Professionnel de la santé interviewé : Psychothérapeute

	APPARTENANCES
Relations entre l'institution et la communauté hispano-américaine	-Consultations thérapeutiques de couple, de famille, d'enfants et individuels. Groupe thérapeutique de mères et enfants en âge préscolaire. - Centre de femmes : activités et cours spécialisés pour les femmes - Espace hommes : activités sociales et cours pour les hommes et les femmes.
Prise en charge	-Pour la moyenne de patients qui ont une stabilité économique et de résidence (permis de séjour) les consultations ont une durée de moyen et long terme (2 -3ans). - Pour le petit pourcentage de clandestins (lequel a diminué grâce aux nouvelles politiques migratoires par lesquelles on peut avoir un permis après certaines années de résidence en Suisse et d'autres critères) qui consultent actuellement, la problématique (crise, précarité) est différent et en conséquence la prise en charge est plus courte. -Fréquence de prise en charge : au début une fois par semaine et après cela diminue avec le temps en fonction de la problématique.
Parcours qui les amène à l'Institution	-Envoyés par des médecins, assistants sociaux, etc. Mais surtout par « bouche-à-oreille ».
Particularités chez les Hispano-américains	Plus d'expérience de thérapie ou au moins plus de connaissances sur la culture psychologique. Cependant, le psychologue reste encore comme un tabou pour certains niveaux sociaux.
Motifs de consultation plus fréquents	Difficultés de famille, de couple et relation parent-enfant. Ce sont des difficultés quotidiennes qui sont aggravées par la situation de migration.
Comportement/attitude en consultation	-Ils sont plus actifs en thérapie et rentrent plus facilement dans une relation affective et de confiance avec le thérapeute. -Plus de facilité pour décoder des commentaires.
Plus Compliants	-Quand on garde une relation affective et respectueuse en même temps.
Plus Réticents	-Pas fréquemment. Mais, c'est surtout avec certains niveaux sociaux élevés (ex : exilés politiques, professionnels) auxquels le patient entre en compétence avec le thérapeute.
Obstacles pour travailler avec les hispano-américains	Matériels : personnes dans un statut illégal qui doivent soudainement arrêter la thérapie pour différents motifs (par exemple difficultés avec la police).
Ressources pour travailler avec	Les collègues et l'institution qui servent toujours de soutien.
Sollicitation des interprètes	Pas souvent. Priorité pour les thérapeutes hispanophones.
Rémunération des interprètes	Avec le prix de la consultation.
Professionnels bilingues à disposition	3 professionnels et 1 personne qui se débrouille avec l'espagnol et fait appel à l'interprète en fonction de la situation.
Perception du travail à 2 et à 3	L'expérience et l'habitude ont créé un confort avec les deux situations.
Lien avec l'interprète	Important, facile, agréable, nécessaire et intéressant.
Effet de l'interprète dans la thérapie	Effet positif sur le patient. Il se sent plus accompagné et a plus de possibilités de s'identifier avec quelqu'un dans la thérapie.

Professionnel de la santé interviewé : Conseillère en Planning Familial

	Département de Gynécologie-obstétrique (DGO) Planning Familial
Relations entre l'institution et la communauté hispano-américaine	Majorité consulte pour interruption volontaire de grossesse (IVG). De fois, consultations après l'accouchement dans le cadre de planning (méthodes contraceptives, reprise de rapports sexuels, « baby Blues »).
Prise en charge et leur durée	Consultation en pré-hospitalitation avant l'IVG généralement d'une à deux fois. Mais, un soutien psychologique ponctuel peut être offert après l'hospitalisation. Quelques fois, 5 ou 6 consultations pour les femmes qui gardent un peu le lien. Facilité pour les femmes de revenir parce que c'est une prestation de l'hôpital.
Parcours qui les amène à l'Institution	Envoyés par la Policlinique Gynécologique (hôpital public). Petit pourcentage par d'autres institutions qui travaillent avec les hispano-américains.
Particularités chez les Hispano-américains	Population qui fait plus de demandes d'IVG. Manque d'information, ou information erronée sur l'éducation sexuelle et la contraception. Situation socio-économique difficile.
Motifs de consultation plus fréquents	Demande d'IVG et Planning familial.
Comportement/attitude en consultation	Soulagement et réassurance d'entendre quelqu'un qui leur parle dans leur langue maternelle.
Plus Compliants	Par rapport au planning, plus compliants quand les informations sont présentées clairement et elles ont le choix.
Plus Réticents	Méfiants à propos des méthodes hormonales.
Obstacles pour travailler avec les hispano-américains	Les assurances, « ce n'est pas parce que c'est légal que l'on l'obtient si facilement ». En plus les prix d'assurances sont énormes pour le revenu de quelques familles. Situation psycho socio-économique en Suisse des patientes (sollicitude, culpabilité).
Ressources pour travailler avec	Consultations assumées par l'institution. Chez les femmes, une force et un courage pour faire face à des circonstances très difficiles. Chez les professionnels, la connaissance plus approfondie de la culture hispano.
Sollicitation des interprètes	Oui, quand il y a de problèmes de communication. Les interprètes, ce sont des professionnels de la maison qui travaillent dans d'autres domaines (ex, infirmières, femmes de ménage).
Rémunération des interprètes	Engagés par le CHUV, mais pour d'autres langues.
Professionnels bilingues à disposition	Une conseillère hispanophone et une autre que « se débrouille »; mais aussi des hispanophones chez les médecins et les anesthésistes dans le service. Sinon des professionnels qui se débrouillent avec l'espagnol même si ce ne sont pas des entretiens très élaborés.
Perception du travail à 2 et à 3	Différent si c'est un membre de la famille, un traducteur ou un traducteur médiateur. Plus difficile quand l'interprète n'a pas la formation.
Lien avec l'interprète	Apprentissage culturel grâce au contact avec les interprètes.
Effet de l'interprète dans la thérapie	Difficulté supplémentaire.

Professionnel de la santé interviewé : Psychiatre

	POLICLINIQUE MEDICAL UNIVERSITAIRE (PMU) SERVICE PSYCHIATRIE DE LIAISON
Relations entre l'institution et la communauté hispano-américaine	Mission de soigner psychiquement des personnes défavorisées, envoyées par les médecins généralistes de la PMU. Ce sont de personnes pour lesquelles la plupart de temps le premier motif de consultation est somatique. En même temps, elles sont envoyées vers la psychiatrie de liaison à cause de symptomatologie psychosomatique et/ou des difficultés psychiques en parallèle avec les problèmes médicaux.
Prise en charge et durée	Durée en fonction du motif de consultation. Elle varie de quelques rencontres à plusieurs consultations pendant quelques années. En général, les patients sont évalués et remis à d'autres services plus spécialisés en fonction de leurs difficultés psychiques. Pour les hispano-américains, les consultations sont plutôt de courte durée.
Parcours qui les amène à l'Institution	Principalement la médicine générale de la PMU.
Particularités chez les Hispano-américains	Population orientée vers la famille et les proches. Bon réseaux de soutien familial ou social avec des gens de la même communauté.
Motifs de consultation plus fréquents	Problèmes psychosomatiques liés au stress. Précarité existentielle.
Comportement/attitude en consultation	Pour la consultation en psychiatrie, les patients ne sont pas accompagnés par leurs proches à la différence d'autres consultations ; ni ces proches sont utilisés comme traducteurs.
Plus Compliants	En général facilement compliants.
Plus Réticents	---
Obstacles pour travailler avec les hispano-américains	---
Ressources pour travailler avec	Ce sont des patients qui fonctionnent mieux que la moyenne dans leurs difficultés.
Sollicitation des interprètes	En général, les hispano-américains qui arrivent à ce service ont un niveau de français assez compréhensible. Par conséquent, il n'y a pas besoin de faire recours aux interprètes. Par contre, dès qu'il existerait des difficultés de communication, ils feraient appel aux interprètes communautaires d'Appartenances. Pour la psychiatrie de liaison, il est souvent important d'avoir un interprète médiateur, ce qui n'est pas tout à fait nécessaire pour la consultation générale, ou cela peut-être un traducteur.
Rémunération des interprètes	Si nécessaire, payés par l'institution.
Professionnels bilingues à disposition	1 personne dans l'équipe de psychiatres et une secrétaire.
Perception du travail à 2 et à 3	Travail à 3 : Plus difficile. Limitation du temps. Préfère le travail à deux.
Lien avec l'interprète	D'ordinaire favorable.
Effet de l'interprète dans la thérapie	Interprète communautaire positif quand la communication doit aller plus loin.

Professionel de la santé interviewé : Assistante Sociale

	L'Hôpital de l'Enfance (HEL)
Relations entre l'institution et la communauté hispano-américaine	Relation de soins ; les patients hispano-américains viennent pour faire soigner leur enfant. Dans le cadre d'assistante sociale : s'assurer que les patients ont une assurance ou dans le cas contraire les guider à la faire ; faire des demandes sociales et des recherches de fonds (si nécessaire) pour aider les familles à payer les frais hospitaliers.
Prise en charge et leur durée	Variété d'un cas à l'autre.
Parcours qui les amène à l'Institution	Enfants malades ou avec des difficultés de santé. Par bouche-à-oreille.
Particularités chez les Hispano-américains	Gens autonomes, qui ne demandent pas beaucoup d'aide mais que quand c'est nécessaire. Intelligents, ils se débrouillent très bien. Très honnêtes. Personnes qui sont toujours en train de se battre. Très actifs. Capacité à accepter de faire des petits boulots, même s'ils ont une formation dans un autre métier. Personnes qui souffrent malgré leur caractère gai. Couples très unis ; liens familiaux très fort. Souvent les femmes des familles arrivent en premier en Suisse.
Motifs de consultation plus fréquents	Enfants malades ou avec des difficultés de santé.
Comportement/attitude en consultation	Au début, ils ont plutôt renfermés et méfiants. Une fois que l'ambiance de confiance est établie, ils s'ouvrent facilement.
Plus Compliants	Dans un climat de confiance et clarté.
Plus Réticents	Cela n'arrive pas souvent, mais quand il existe c'est à cause d'une mauvaise compréhension du rôle du professionnel.
Obstacles pour travailler avec les hispano-américains	Limitations de la loi pour aider les clandestins et limitations financières pour aider les étrangers. Chez les patients, changements fréquents de résidence ou des contacts téléphoniques sans l'annoncer. La langue.
Ressources pour travailler avec	Patients avec une bonne capacité d'adaptation au niveau du fonctionnement du système et à la langue. Capacité énorme pour gérer et vivre avec des difficultés. Interprètes à disposition.
Sollicitation des interprètes	Pas systématiquement. Le français chez les patients est suffisant pour se faire comprendre. Quand se fait l'appel aux interprètes : d'autres professionnels ou personnes de la maison pour la transmission des informations basiques. Au niveau de consultation médicale, les enfants sont convoqués quand il y a la permanence avec un interprète professionnel hispanophone toutes les deux semaines, une demi-journée.
Rémunération des interprètes	Un fond qui a été crée dans ce but.
Professionnels bilingues à disposition	Nombre incertain. En tout cas, il y a une infirmière.
Perception du travail à 2 et à 3	Le travail à 3 demande beaucoup plus de temps, mais si c'est en présence d'un interprète professionnel c'est très riche.
Lien avec l'interprète	Collaboration avec un autre professionnel pour bien comprendre le patient et pour mieux se faire comprendre.
Effet de l'interprète dans la thérapie	L'interprète professionnel va améliorer la communication avec les patients en apportant des éléments culturels.

Professionnel de la santé interviewé : Médecin généraliste

	POLICLINIQUE MEDICALE UNIVERSITAIRE (PMU)
Relations entre l'institution et la communauté hispano-américaine	Relation historique depuis début des années 2000. Mission de soigner des personnes défavorisées entre autres les clandestins dont 50% appartiennent à la communauté latino-américaine.
Prise en charge et durée	Egalité et bonne qualité de soins malgré leur statut. Procédure différente pour les paiements. Durée en fonction des motifs de consultation. Consultations plus longues quand il y a la barrière de communication. Grand pourcentage qui consulte ponctuellement, soins d'urgence. Plus de difficulté d'adhérence au traitement des longues durées (ex : tuberculose) à cause de leur statut.
Parcours qui les amène à l'Institution	Principalement « bouche-à-oreille ». Petit pourcentage envoyé par Point d'Eau, CHUV ou institutions caritatives de la ville de Lausanne.
Particularités chez les Hispano-américains	Très respectueux du corps médical et particulièrement du médecin. Beaucoup plus dans le contact physique. Consultations beaucoup plus animées dans le sourire/rire ou dans les pleurs. Cordiales. Assez ponctuels quand ils viennent et sont adhérents au traitement. Par contre, tendance à banaliser les médicaments (ex : dévalorisent la nécessité d'une ordonnance, un médicament peut être bien pour tout). Importance de la spiritualité !
Motifs de consultation plus fréquents	Femmes extrêmement attentives à l'état de la peu (ex : problèmes d'hyperpigmentation). Conséquences de leur activité labourable (mal au ventre et mal au dos). Stress : 8e ou 9e motif.
Comportement/attitude en consultation	Très émotifs. Douceur dans la consultation, respect pour la personne du médecin.
Plus Compliants	En général complaints s'il y a de la confiance. Face à la gravité, facilement compliants. Le plus stable est la structure et leur environnement social et économique le plus compliants.
Plus Réticents	Fautes de communication. Quand la médecine ne réussit pas à faire passer le message.
Obstacles pour travailler avec les hispano-américains	De temps en temps, l'exubérance des émotions dans les extrêmes.
Ressources pour travailler avec	Capacité de résiliance « joyeuse ». Bon humeur, rirent de presque de tout sans banaliser.
Sollicitation des interprètes	Pas de réseau officiel pour les interprètes. La communauté se débrouille assez bien avec la similitude de la langue ou en emmenant quelqu'un pour traduire dans la consultation. Idéal : problème psychiatrique, problème de complexité majeur et impact important de la communication sur le déroulement d'un suivi.
Rémunération des interprètes	Le patient doit payer l'interprète.
Professionnels bilingues à disposition	Dans la consultation générale : 6 – 8 personnes.
Perception du travail à 2 et à 3	Travail à 3 : n'est pas intuitif. Professionnels ne sont pas formés pour le travail en trialogue. Plus difficile. Limitation du temps. Extraordinaire quand il y a une formation et une habitude. Surtout avec les interprètes communautaires.
Lien avec l'interprète	Lien doit être tissé et travaillé pour que ça marche. Formation nécessaire pour établir ce lien. Une structure disponible pourrait faciliter la création du lien.
Effet de l'interprète dans la thérapie	Interprète communautaire positif quand la communication doit aller plus loin. Aider la compréhension de la personne.

Professionnel de la santé interviewé : Infirmière

	ASSOCIATION POINT D'EAU
Relations entre l'institution et la communauté hispano-américaine	Soins liés à la santé : médical et infirmerie. Pourcentage élevé pour les consultations (ostéopathe, masseurs, dentiste, podologue, psychologue, infirmière psychiatrique, gynécologue) et pourcentage bas pour les prestations au niveau de l'hygiène (lessive, douches) pour les personnes plus démunies. Pour les accompagnements psychologiques, l'équipe est supervisée par un psychiatre. En tout cas, les situations difficiles sont référées à des unités psychiatriques. Consultations infirmières gratuites. Consultations dentiste : 40 CHF Autres : 5 CHF Groupes de rencontre sur un thème spécifique une fois par mois (la ménopause, l'alcoolisme, comment faire des bijoux, stress, etc).
Prise en charge et leur durée	Variété en fonction du consultant et dans quel domaine.
Parcours qui les amène à l'Institution	« Bouche-à-oreille ».
Particularités chez les Hispano-américains	Parlent extrêmement mal le français donc ce sont des personnes isolées dans leur communauté. Population correcte, discrète, travailleuse. Dans la nouvelle migration, les femmes sont beaucoup plus nombreuses. Elles sont émigrées seules sans leurs enfants. Solidarité, mais sentiment de compétition au niveau du travail et de recherche de logement à cause de la concurrence.
Motifs de consultation plus fréquents	Premiers motifs de consultation : problèmes dermatologiques, douleurs musculaires qui ont souvent une origine psychologique.
Comportement/attitude en consultation	Très demandeurs de médicaments ; laissent le choix au médecin pour le médicament. Déstabilisés par l'approche de la médecine où il y a plus de place pour que le patient puisse prendre une partie active dans le choix de son médicament. Le professionnel à toute la connaissance. Personnes très reconnaissantes, polies et correctes.
Plus Compliants	Avec un climat de confiance.
Plus Réticents	Quand ils ne reçoivent pas facilement de médicament.
Obstacles pour travailler avec les hispano-américains	Leurs manques des rendez-vous des fois non excusés, surtout à cause de leur travail. Difficultés pour avoir une continuité dans leurs suivis. Appel aux interprètes professionnels à cause de ressources financières limitées.
Ressources pour travailler avec	Solidarité énorme dans le réseau professionnel. Chez les patients, force intérieure qui les aide à avancer avec un minimum du soutien. « Femmes plus fortes que la moyenne ». Foi et religion catholique.
Sollicitation des interprètes	Oui, principalement pour les suivis psychologiques, ce sont les mêmes professionnels hispanophones de la maison qui traduisent. De temps en temps, des bénévoles.
Rémunération des interprètes	Pas de rémunération.
Professionnels bilingues à disposition	5 professionnels (assistante sociale, accueil, hygiéniste dentaire, coordinateur, infirmière), dont 3 sont présents régulièrement. Autres professionnels qui ont des connaissances, mais travaillent avec un traducteur.
Perception du travail à 2 et à 3	Communication plus facile et directe dans le travail à 2. Avec un interprète communautaire c'est une grande richesse parce qu'ils peuvent donner des indications par rapport à la culture de la personne. Difficulté quand l'un interprète est un ami et quelqu'un de la famille parce que ça dérange la communication et son contenu.
Lien avec l'interprète	Interprète professionnel : confiance Traducteur extérieur : difficultés supplémentaires Très varié en fonction du type d'interprète.
Effet de l'interprète dans la thérapie	En fonction du type d'interprète. Ceux qui ont une formation dans la santé communautaire peuvent donner un effet positif, mais sinon ça peut être délicat. Il y a tout les nuances possibles, mais il vaut mieux un traducteur non formé qui rien du tout. Ils évitent la traduction par l'enfant du parent (au moins que ce soit urgent ou une situation ponctuelle). Même le conjoint, ça peut être délicat. Mais, des fois, les patients veulent absolument quelqu'un de la famille. En même temps quand il y a une difficulté personnelle, ils parlent plus facilement en l'absence de quelqu'un de la famille. Importance de prendre du temps avant et après la consultation.

Professionnel de la santé interviewé : Conseillère en Planning Familial

	FONDATION PROFA – Migration et Intimité
Relations entre l'institution et la communauté hispano-américaine	Principalement à Renens, forte vague de patients latino-américains entre 1997-2003. En 2003, ils ont atteint le 71% total de consultants. Programme Latino Santé le vendredi soir (une fois par mois pendant deux ans) où des thèmes liés à la santé et à la migration étaient discutés. Création du Programme Migration et Intimité en 2003 en partenaire avec Le Point Fixe. Il s'adresse aux migrants, spécifiquement aux latino-américains et aux africains-sub-sahariens. Actuellement, ateliers en santé sexuelle et reproductive sur le terrain collectif (fêtes, festivals, lieux de rencontre, etc.) *Selon le Bilan 2006-2008, la création du projet a été motivée en fonction des données statistiques vaudoises en 2006 qui mettait en évidence que la plupart des IVG étaient faites par des migrantes de ces deux origines. Ce programme a ciblé les migrants qui consultent les réseaux de santé et les migrants à l'écart pour des diverses raisons (« méconnaissance du système socio-sanitaire, peur, absence de permis, mauvaise connaissance de la langue, etc »). Le programme Migration et Intimité est né comme un projet pilote, mais dans l'actualité il s'est institutionnalisé au sein de la Fondation (Planning familial, Conseil en Périnatalité) et Point Fixe.* Aussi des consultations en Planning Familial (examens gynécologiques, contraception) à Renens. Soutien financier dans ces services pour des personnes sans assurance qui sont souvent représentées par des clandestins dont une majorité appartient à cette communauté. La plupart du temps, la population qui consulte est constituée par des nouveaux arrivants en Suisse.
Prise en charge et leur durée	Varié en fonction de la demande. Hispano-américains qui vient une fois par année pour les contrôles annuels. Comme elles sont déjà intégrées, il y a moins de demandes.
Parcours qui les amène à l'Institution	Bouche-à-oreille principalement.
Particularités chez les Hispano-américains	Population précaire qui change avec fréquence (travail, résidence). Femmes qui vivent la solitude même si aujourd'hui elles sont moins isolées grâce à la création et présence des Associations latino-américaines. Les femmes avec un partenaire étranger ont tendance à imposer leur langue d'origine comme moyen de communication dans le couple. Femmes assez fertiles. Fortes émotionnellement. Solidaires, mais méfiantes vers les autres personnes de leur communauté.
Motifs de consultation plus fréquents	Problèmes psychosomatiques représentés par des « maux au ventre ».
Comportement/attitude en consultation	Bien organisées ; donnent une importance énorme à l'aspect physique : bien entretenues, habillées, maquillées. Besoin de bien comprendre les choses pour prendre des décisions.
Plus Compliants	Quand elles ressentent la possibilité de participer à choisir leur méthode contraceptive. Quand elles se sont valorisées.
Plus Réticents	Quand elles ressentent que l'on essaie d'imposer des choses.
Obstacles pour travailler avec les hispano-américains	-
Ressources pour travailler avec	-
Sollicitation des interprètes	Non.
Rémunération des interprètes	Pas de budget pour les interprètes. FAREAS paie pour les traducteurs envoyés pour eux-mêmes.
Professionnels bilingues à disposition	Une conseillère en planning.
Perception du travail à 2 et à 3	Communication à deux est plus directe, cela permet d'accéder plus facilement au langage non-verbal. L'interprète n'arrive pas à faire cela : communiquer le verbale et non-verbal. En plus la consultation est basée énormément sur le non-verbal « Difficile à faire circuler les émotions à trois ».
Lien avec l'interprète	Difficile parce que, de fois, il peut avoir un lien positif entre le thérapeute et l'interprète, mais pas entre l'interprète et le consultant ou vice versa entre les différentes dyades de la triade.
Effet de l'interprète dans la thérapie	Impact sur l'intimité et confidentialité quand surtout quand l'interprète est un non-professionnel.

Professionnel de la santé interviewé : Sage-femme conseillère, référent/coach

	FONDATION PROFA – Conseil en Périnatalité (grossesse-maternité–paternité)
Relations entre l'institution et la communauté hispano-américaine	Projet migration (planning). Consultations pour des femmes enceintes surtout dans la ville de Renens. Consultations de grossesse (préparation de la naissance dans un contexte varié) avec une sage-femme conseillère (travail psychosocial) et consultations en orientation sociale, économique et au sujet de filiation avec une assistante sociale.
Prise en charge et leur durée	Ça peut être un entretien unique ou plusieurs entretiens dans le même domaine ou dans les deux différents domaines offerts par l'institution. Les consultations sage-femme s'arrêtent à la naissance de l'enfant, par contre l'assistante sociale peut poursuivre son travail jusqu'à 6 mois après la naissance de l'enfant pour finir les projets qui ont été mis en place.
Parcours qui les amène à l'Institution	Par les gynécologues, par le service de Planning Familial, par d'autres professionnels.
Particularités chez les Hispano-américains	Histoire de femmes plutôt que de couples pour beaucoup de sans-papiers. Femmes qui sont venues seules pour débloquer des difficultés économiques dans leurs pays. Elles gardent un lien fort avec leurs réseaux dans leurs pays, avec leurs origines. Femmes qui sortent, qui vont travailler, qui sont actives dans la société.
Motifs de consultation plus fréquents	Renseignements sur leurs droits et sur les aides auxquelles elles peuvent bénéficier en attendant un bébé.
Comportement/attitude en consultation	Capacité de résistance, de force pour se trouver dans une situation instable sans sécurité.
Plus Compliants	-
Plus Réticents	-
Obstacles pour travailler avec les hispano-américains	La langue.
Ressources pour travailler avec	Ouvertes pour faire des demandes et utiliser les ressources dans la communauté.
Sollicitation des interprètes	Non, pas une politique très claire au niveau d'interprétariat. Utilisation des images, des livres et de la communication non-verbale pour se faire comprendre. Si la compréhension est difficile, les consultantes doivent revenir avec quelqu'un qui traduise. S'il y a besoin d'un échange plus intime, ils font appel à un collègue qui parle la langue. Bases d'espagnol chez quelques collaborateurs.
Rémunération des interprètes	Non.
Professionnels bilingues à disposition	Pas dans ce service.
Perception du travail à 2 et à 3	Intéressant quand c'est un professionnel, parce que ça facilite l'échange culturel.
Lien avec l'interprète	Le lien est « bon » si c'est un lien à trois. Il est positif quand il y a un échange des représentations, des pratiques.
Effet de l'interprète dans la thérapie	Un bon interprète va potentialiser la rencontre parce qu'il va aller au-delà de la traduction de mots pour transmettre la signification.

Professionnel de la santé interviewé : Conseillère en Santé Sexuelle et reproductive

	FONDATION PROFA – Planning Familial
Relations entre l'institution et la communauté hispano-américaine	Entretiens de consultation de planning (contraception, ambivalence de la grossesse, difficultés sexuelles, maladies sexuelles) pour les femmes et leurs compagnons quand ils souhaitent être présents. Ateliers de santé sexuelle et reproductive.
Prise en charge et leur durée	Variation entre 1 et 4 fois. Les consultants arrivent d'abord chez la conseillère et en fonction de leur demande, elles sont adressées chez le médecin.
Parcours qui les amène à l'Institution	Bouche-à-oreille principalement. Des fois, envoyés par d'autres institutions dans les réseaux de santé.
Particularités chez les Hispano-américains	Femmes qui ont vécu des parcours difficiles dans leurs vies.
Motifs de consultation plus fréquents	Contraception et examen gynécologique.
Comportement/attitude en consultation	Animées, vivantes, curieuses ; grande envie de comprendre et de connaître.
Plus Compliants	
Plus Réticents	Avec la pilule : croyances culturelles contre l'utilisation de la pilule. Confusion entre la pilule d'urgence et la pilule quotidienne.
Obstacles pour travailler avec les hispano-américains	La langue. Pour les clandestins, limitation pour pouvoir utiliser quelques structures.
Ressources pour travailler avec	Utilisation de moyens de communication non-verbale pour faciliter la consultation comme par exemple : fiches en espagnol, images, maquettes, objets. Quand le partenaire est impliqué, ça devient une ressource pour le travail fait avec ces femmes.
Sollicitation des interprètes	Très peu. Environs 7 fois sur une centaine de consultations. La réception du service, avec l'accord de la consultante, détermine si la personne aura besoin d'un interprète ou pas. Ensuite, elle donne le choix à la personne de venir avec quelqu'un ou d'avoir quelque à disposition par l'institution.
Rémunération des interprètes	-
Professionnels bilingues à disposition	Pas à Lausanne, mais à Renens.
Perception du travail à 2 et à 3	C'est un travail tout à fait différent. Le travail à 3 demande un degré de confiance très élevé (que le traducteur traduise correctement). En même temps, il y a une perte de subtilité du langage implicite et de sa richesse. Travail subjectif, spécialement si l'interprète n'est pas un professionnel.
Lien avec l'interprète	Difficile quand il s'agit d'un nouvel interprète : « rendre la confiance en 30 secondes à quelqu'un que l'on ne connaît pas du tout ». S'il s'agit d'un professionnel, il y a un avantage sur la confiance et la confidentialité.
Effet de l'interprète dans la thérapie	L'effet varie en fonction du type d'interprète. En général, facilitation de la communication quand il n'existe pas une compréhension commune à cause de différentes langues.

Professionnel de la santé interviewé : Infirmière et Sage Femme Consultante

	DEPARTEMENT DE GYNECOLOGIE-OBSTETRIQUE (DGO) **Policlinique Maternité**
Relations entre l'institution et la communauté hispano-américaine	Consultations gynécologiques et obstétriques pour des femmes enceintes. Suivis individuels des grossesses et en collaboration avec des médecins et gynécologues.
Prise en charge et durée	Suite au premier entretien avec un médecin, une demi-heure de consultation pour les suivis individuels (sage-femme) toutes les 6 semaines. Suivi arrive à la fin avec la fin de la grossesse.
Parcours qui les amène à l'Institution	Par « bouche-à-oreille » principalement.
Particularités chez les Hispano-américains	Souvent des femmes sans permis qui vivent dans des conditions difficiles, dans une situation psychosociale précaire. Fréquemment ne possèdent pas une assurance. Femmes qui travaillent régulièrement au noir ; qui travaillent pendant la grossesse pour pouvoir survivre ou envoyer de l'argent à leurs familles. Elles se trouvent dans des conditions non idéales pour le vécu d'une grossesse (menaces par rapport leur statut d'illégale, enfants non désirés par leur conjoint). Beaucoup plus de situation où il existe une tension psychologique.
Motifs de consultation plus fréquents	Grossesse
Comportement/attitude en consultation	Une autre manière de répondre aux questions (moins directe, apportant plus d'associations). Professionnel devient quelqu'un de très important sur lequel elles peuvent compter parce que ce sera un soutien dans leurs parcours. Expressives dans les marques d'attention et de remerciement. Attitude de confiance. Peur de la naissance d'un enfant dans l'illégalité. Soutien dans la communauté hispano-américaine et religieuse. Solidarité entre femmes.
Plus Compliants	En général facilement compliants.
Plus Réticents	Méfiance au départ. Plus réticence quand il n'y a pas de transparence.
Obstacles pour travailler avec les hispano-américains	Une relation de confiance qui n'a pas pu être établie qui conduit à une non-ouverture.
Ressources pour travailler avec	Pas de refus de suivi par l'institution, même en situation de clandestinité.
Sollicitation des interprètes	Pas pour les hispanophones. Cette professionnelle, elle-même, est facilement sollicitée comme interprète pour d'autres consultations. Sinon, la patiente peut être demandée d'amener une connaissance à la consultation pour faire la traduction. En Policlinique, « les médecins apprennent à consulter avec des femmes qui ne parlent pas vraiment bien ou qui parlent peu. C'est un art de l'on développe à la langue ».
Rémunération des interprètes	Non
Professionnels bilingues à disposition	2 professionnels bilingues fixes et quelques professionnels disponibles irrégulièrement.
Perception du travail à 2 et à 3	Le travail avec un interprète est fatigant. Il y a quelque chose dans la qualité de l'information recherchée qui se perd. L'accès direct à la personne est plus simple. Passer par le traducteur pour le complément ou précision
Lien avec l'interprète	Ça dépend du type d'interprète.
Effet de l'interprète dans la thérapie	Il est très utile surtout les interprètes médiateurs culturels. Effet positif si la patiente a confiance dans l'interprète.

Professionnel de la santé interviewé : Psychiatre

	CABINET PRIVE
Relations entre l'institution et la communauté hispano-américaine	En réalité, il y en a très peu dans l'actualité. Cependant, plusieurs cas d'enfants hispano-américains adoptés par des suisses.
Prise en charge et leur durée	Très variable. Cela peut être quelques séances ou plusieurs années. Il y a des personnes qui sont suivies pendant de longues durées, même si ce n'est pas intensif. Ces personnes ont peu de liens sociaux et la relation avec eux est comme « un espèce de fils, du cordon ombilical » avec la société d'accueil.
Parcours qui les amène à l'Institution	Bouche à oreille.
Particularités chez les Hispano-américains	Difficulté de classifier les gens d'une structure parce que une personne a des multiples appartenances et l'appartenance culturelle se crée constamment en contact avec un nouveau contexte.
Motifs de consultation plus fréquents	Problématique de couple et adoption. Difficulté de réinsertion scolaire et comportement chez les enfants et adolescents. Egalement d'autres, problématiques liées à la précarité et absence de statut.
Comportement/attitude en consultation	Pas de comportement ou attitude spécifique identifiable. Cependant, plus de familiarité avec la thérapie en comparaison avec d'autres cultures ce qui peut faciliter le traitement.
Plus Compliants	Situations particulières qui changent d'une à l'autre et empêchent de faire des généralités. Cependant, la compliance peut être favorisée par la relative facilitée chez le thérapeute à établir du contact chez les Hispano-américains dû à des connaissances linguistiques et culturelles.
Plus Réticents	-
Obstacles pour travailler avec les hispano-américains	-
Ressources pour travailler avec	Quelque chose du ressort de la « combativité ». De ne pas « se laisser réduire à une position de victime » par rapport a leur difficultés de vies. Capacité pour chercher des solutions créatives chez les Hispano-américains.
Sollicitation des interprètes	Pas dans cette langue.
Rémunération des interprètes	-
Professionnels bilingues à disposition	Un thérapeute hispanophone suit le peu de situations de patients de cette origine.
Perception du travail à 2 et à 3	Très positif le travail à trois. C'est un élément souvent essentiel parce que peut diminuer « le fossé ». Le travail avec des interprètes permet de lier deux appartenances et avoir accès à toute une série de significations et manières de voir le monde. Le travail à deux avec un patient qui parle la même langue, des fois pourrait être incomplet parce qu'il manquerait ce lien culturel.
Lien avec l'interprète	Il est positif. L'interprète n'est pas une machine à traduire, mais doit avoir sa propre parole. Il permet le patient de se sentir mois seul face au thérapeute.
Effet de l'interprète dans la thérapie	De manière générale très positif.

Annex G: Positive Alliance with the Therapist (Complete results of the coding process)

POSITIVE ALLIANCE				
	Codes	***Categories***	***Themes***	***% (Frequency)***
Therapist	Acceptance of mistakes Honesty and frankness Transparency	Authenticity	Authenticity in Being/Doing	3%
	Positive attitude **Kindness and gentleness** **Welcomed reception** **Warmth** **Space to share experiences**	**Hospitality**	**Hospitality and Warmth**	**13%**
	Support Team assistance Help	Assistance	Assistance	**11%**
	Goodness **Understanding** **Listening** **Patience** **Respect** **Sensitivity**	**Human Values**	**Human Values and Qualities**	**13%**
	Satisfaction	Satisfaction	Satisfaction of Service Received	3%
	Trust **Previous knowledge of each other** **Empathy** **Security** **Tranquility**	**Bond**	**Emotional Bond**	**13%**

	Self-disclosure Shared knowledge Control over the therapy Symmetry Cultural similarities Linguistic similarities	Equality	Equal Positions	**7%**
	Guidance	**Guidance**	**Conflict Resolution Guidance**	4%
	Close contact Spanish learning efforts Helping efforts Interest and concern	Beyond	Above and Beyond Professional Duties	**10%**
	Confidentiality **Professionalism**	**Ethics**	**Professional Ethics**	4%
	Exchange and dialogue Team work	Reciprocity	Reciprocity in the Relationship	2%
	Communication clarity **Interpreter's presence** **Communication bridge**	**Communication**	**Good Quality of Communication**	**6%**
	Efficacy Progress and change	Progress and Change	Health Improvement and Change	**7%**
	Availability **Impartiality** **Unconditional presence** **Follow-up**	**Permanency**	**Permanency During Accompaniment**	4%
	Dynamism	Dynamism	Dynamism in the Therapy's Methods	0%

Annex H: Positive Alliance with the Interpreter (Complete results of the coding process)

POSITIVE ALLIANCE				
	Codes	***Categories***	***Themes***	***% (Frequency)***
Interpreter	Warmth	Hospitality	Hospitality and Warmth	**7%**
	Support **Help**	**Assistance**	**Assistance**	**31%**
	Goodness Understanding Patience	Human Values	Human Values and Qualities	**10%**
	Reliability **Security**	**Bond**	**Emotional Bond**	6%
	Complicity Linguistic similarities	Equality	Equal Positions	6%
	Guidance	**Guidance**	**Conflict Resolution Guidance**	4%
	Close contact Concern	Beyond	Above and Beyond Professional Duties	**16%**
	Confidentiality	**Ethics**	**Professional Ethics**	3%
	Communication bridge Simultaneous translation	Communication	Good Quality of Communication	**15%**

Annex I: Negative Alliance with the Therapist and the Interpreter: Complete results of the coding process

NEGATIVE ALLIANCE				
	Codes	***Categories***	***Themes***	***% (Frequency)***
Therapist	Lack of truth	Lack of Truth	Lack of Truth in Doing	5%
	Abuse	**Inhospitality**	**Inhospitality and Lack of Warmth**	6%
	Lack of respect	Lack of Human Values	Lack of Human Values and Qualities	2%
	Insecurity **Mistrust**	**Lack of Bond**	**Lack of Emotional Bond**	**10%**
	Asymmetry Lack of control over the therapy Feeling of abnormality Feeling of difference	Inequality	Unequal Positions	**24%**
	Economic interest **Thoughtlessness of the patient's interest**	**Disinterest**	**Disinterest in the Patient's Well-being**	11%
	Understanding problems Expression problems	Communication Difficulties	Poor Quality of Communication	**13%**
	Lack of change	**Lack of Change**	**Lack of Health Improvement and Change**	4%
	Frequent change of therapist Ambiguity	Instability	Instability in Therapy	4%
	Lack of dynamism	**Lack of Dynamism**	**Lack of Dynamism in the Therapy's Methods**	**12%**
Interpreter	Lack of support	Non-assistance	Non-assistance	2%
	Devaluation **Discrimination** **Judgmental attitude**	**Lack of Recognition**	**Lack of Recognition of the "Whole Person"**	**8%**
	Breaking confidentiality	Lack of Ethics	Lack of Professional Ethics	**2%**

Annex J: Factors that positively and negatively influence the therapeutic alliance in a Dyadic setting vs. a Triadic setting

	Dyad	%		Triad	%	Themes	Total % Dyad	Total % Triad
INTERPRETER'S ALLIANCE -								
Breaking Confidentiality	0	0		1	100%	Lack of Professional Ethics		100%
Total=	0	0		1	100%	Total retained for analyses=		80%
INTERPRETER'S ALLIANCE +								
Support	0	0%		5	14%	Assistance		38%
Help	0	0%		9	24%	Assistance		38%
Goodness	0	0%		2	5%	Human Values and Qualities		5%
Warmth	0	0%		3	8%	Hospitality and Warmth		8%
Complicity	0	0%		1	3%	Equal Positions		
Understanding	0	0%		1	3%	Human Values and Qualities		
Confidentiality	0	0%		1	3%	Professional Ethics		
Close Contact	0	0%		3	8%	Above and Beyond Professional Duties		16%
Reliability	0	0%		1	3%	Emotional Bond		
Guidance	0	0%		2	5%	Conflict Resolution Guidance		5%
Patience	0	0%		1	3%	Human Values and Qualities		
Concern	0	0%		3	8%	Above and Beyond Professional Duties		16%
Communication bridge	2	0%		3	8%	Good Quality of Communication		8%
Security	0	0%		1	3%	Emotional Bond		
Linguistic similarities	0	0%		1	3%	Equal Positions		
Simultaneous translation	0	0%		1	3%	Good Quality of Communication		
Total=	2	0%		37	100%	Total retained for analyses=		80%
THERAPIST'S ALLIANCE -								
Ambiguity	1	2%		0	0%	Instability in Therapy		
Asymmetry	5	10%		0	0%	Unequal Positions	35%	
Frequent change of therapist	1	2%		0	0%	Instability in Therapy		
Mistrust	2	4%		2	18%	Lack of Emotional Bond		18%
Thoughtlessness of the patient's interest	6	12%		0	0%	Disinterest in the Patient's Well-being	12%	
Devaluation	1	2%		0	0%	Lack of Recognition of the "Whole Person"		
Discrimination	3	6%		0	0%	Lack of Recognition of the "Whole Person"	6%	
Lack of support	1	2%		0	0%	Non-assistance		
Lack of change	3	6%		0	0%	Lack of Health Improvement and Change	6%	
Lack of dynamism	10	19%		0	0%	Lack of Dynamism in the Therapy's Methods	19%	
Lack of control over the therapy	2	4%		0	0%	Unequal Positions		
Lack of respect	1	2%		0	0%	Lack of Human Values and Qualities		
Lack of truth	2	4%		0	0%	Lack of Truth in Doing		
Insecurity	1	2%		1	9%	Lack of Emotional Bond		
Economic interest	0	0%		0	0%	Disinterest in the Patient's Well-being		
Abuse	4	8%		0	0%	Inhospitality and Lack of Warmth	8%	
Judgmental attitude	1	2%		0	0%	Lack of Recognition of the "Whole Person"		
Understanding problems	2	4%		4	36%	Poor Quality of Communication		54%
Expression problems	1	2%		2	18%	Poor Quality of Communication		54%
Feeling of abnormality	7	13%		0	0%	Unequal Positions	35%	
Feeling of difference	6	12%		2	18%	Unequal Positions	35%	18%
Total =	52	100%		11	100%	Total retained for analyses=	86%	90%

THERAPIST'S ALLIANCE +								
Acceptance of mistakes	1	0%		0	0%	Authenticity in Being/Doing		
Positive attitude	1	0%		0	0%	Hospitality and Warmth		
Kindness and gentleness	10	4%		2	2%	Hospitality and Warmth	15%	
Support	5	2%		6	6%	Assistance		18%
Team assistance	4	2%		0	0%	Assistance		
Self-disclosure	0	0%		1	1%	Equal Positions		
Help	15	6%		12	12%	Assistance	6%	18%
Goodness	2	1%		2	2%	Human Values and Qualities		
Welcomed reception	9	4%		4	4%	Hospitality and Warmth	15%	9%
Warmth	7	3%		2	2%	Hospitality and Warmth	15%	
Communication clarity	7	3%		0	0%	Good Quality of Communication	3%	
Shared knowledge	0	0%		0	0%	Equal Positions		
Understanding	7	3%		6	6%	Human Values and Qualities	6%	13%
Close contact	12	5%		6	6%	Above and Beyond Professional Duties	11%	11%
Trust	22	9%		4	4%	Emotional Bond	12%	4%
Confidentiality	1	0%		1	1%	Professional Ethics		
Previous knowledge of each other	1	0%		2	2%	Emotional Bond		
Dynamism	1	0%		0	0%	Dynamism in the Therapy's Methods		
Availability	2	1%		0	0%	Permanency During Accompaniment		
Efficacy	1	0%		0	0%	Health Improvement and Change		
Empathy	5	2%		2	2%	Emotional Bond		
Listening	6	2%		2	2%	Human Values and Qualities		
Spanish learning efforts	0	0%		1	1%	Above and Beyond Professional Duties		
Helping efforts	6	2%		0	0%	Above and Beyond Professional Duties		
Space to share knowledge	9	4%		5	5%	Hospitality and Warmth	15%	9%
Guidance	10	4%		4	4%	Conflict Resolution Guidance	4%	4%
Honesty and frankness	4	2%		1	1%	Authenticity in Being/Doing		
Impartiality	1	0%		0	0%	Permanency During Accompaniment		
Exchange and dialogue	3	1%		0	0%	Reciprocity in the Relationship		
Interest and concern	15	6%		5	5%	Above and Beyond Professional Duties	11%	11%
Control over the therapy	2	1%		1	1%	Equal Positions		
Patience	0	0%		3	3%	Human Values and Qualities		13%
Interpreter's presence	1	0%		10	10%	Good Quality of Communication		10%
Unconditional presence	9	4%		3	3%	Permanency During Accompaniment	4%	3%
Professionalism	11	4%		1	1%	Professional Ethics	4%	
Progress and change	19	7%		7	7%	Health Improvement and Change	7%	7%
Communication bridge	3	1%		1	1%	Good Quality of Communication		
Respect	7	3%		4	4%	Human Values and Qualities	6%	13%
Satisfaction	16	6%		0	0%	Satisfaction of Serviced Received	6%	
Follow-up	3	1%		0	0%	Permanency During Accompaniment		
Security	8	3%		0	0%	Emotional Bond	12%	
Sensitivity	5	2%		0	0%	Human Values and Qualities		
Symmetry	1	0%		0	0%	Equal Positions		
Cultural similarities	15	6%		0	0%	Equal Positions	6%	
Linguistic similarities	5	2%		1	1%	Equal Positions		
Team work	2	1%		0	0%	Assistance		
Tranquility	3	1%		0	0%	Emotional Bond		
Transparency	0	0%		3	3%	Authenticity in Being/Doing		3%
total=	256	100%		98	100%	Total retained for analyses=	84%	82%