Exploring the experiences of Polish interpreters who interpret for mental health professionals: An Interpretative Phenomenological Analysis

This thesis is submitted for the degree of Doctorate in Clinical Psychology (DClincPsy) at the University of Leicester

By

Colm Gallagher

2015
Declaration

I can confirm that the research reported within this document is original, my own work and has not been submitted for any other academic award.

Colm Gallagher
Exploring the experience of Polish interpreters who interpret for mental health professionals: An Interpretative Phenomenological Analysis

Colm Gallagher

Thesis Abstract

Literature Review

The aim of the review was to explore the research literature in relation to the experiences of interpreters of migrants in a mental health context. A systematic review of the literature was carried out in order to provide a thematic synthesis of the findings of previous research. Of the 1805 articles found, eleven met the inclusion criteria for the review. The process followed Thomas and Harden (2008) recommendation of data collection, critical appraisal and thematic synthesis. In total, five themes were uncovered. These were ‘mental health interpreting is an enhanced role’; ‘bearing witness’; ‘emotional impact’; ‘relationship matters’ and ‘coping (trial and error)’. The literature purported to show the added complexities of interpreting when compared to non mental health settings. Interpreters can be emotionally affected whilst working in mental health settings, this can relate to bearing witness to traumatic stories which can cause distress and affect their wellbeing.

Research Report

The research aimed to understand how Polish interpreters experience their roles in adult mental health settings and to understand how they view the triadic relationship between themselves, client and mental health professional when interpreting. Six participants were recruited from interpreting services and each took part in semi-structured interviews. Interviews were analysed using Interpretative Phenomenological Analysis. The participants’ accounts clustered around one superordinate theme of ‘being paid to be a machine for a human role’. This was made up of three themes: ‘Just a linguist?’, ‘Unspoken alliances’ and ‘Communicating emotional reactions’. The findings of the current research emphasise the importance for clinicians, mental health and interpreting services to take into account the emotional impact, and disempowerment caused by structural systemic factors which limit the voice of the interpreter.

Critical Appraisal

Finally, the critical appraisal offers the researchers’ reflections on the research process, methodological limitations and proposals for future research.
Acknowledgements

I would like to thank the six participants who give their time to share their experiences with me. It was an honour and a privilege to be allowed to listen to their stories and to make this research possible.

I would like to acknowledge the support and encouragement I have received throughout the entire research process from my supervisors, Steve Melluish and Saima Lofgren. Their guidance, motivation and support throughout the process was invaluable.

I would like to thank my family for their guidance over the three years. To Joanne and the McCoys for their support and distractions when needed; Michelle and the Lawsons, for their assistance during those critical times. I’d also like to thank Steven Carroll for his guidance towards the end. Much appreciated.

Finally, I would like to thank Nahielly, for her love and inspiration throughout the process. Thank you for believing in me. Te amo.
Word Count

Word Count for main text and abstracts (tables, references and mandatory appendices not included)

Thesis Abstract: 300

Part one: Literature Review: 7566
Abstract: 285

Part two: Research Report: 13,468
Abstract: 265

Part three: Critical Appraisal: 3349

Total word count for main text: 24,383
Total word count for appendices (non-mandatory): 4412
Total word count for whole thesis: 28,795
## Table of Contents

Declaration ................................................................................................................. 2  
Thesis Abstract ........................................................................................................... 3  
Acknowledgements .................................................................................................... 4  
Word Count ................................................................................................................ 5  
Table of Contents ...................................................................................................... 6  
List of Appendices .................................................................................................... 9  
List of Tables ............................................................................................................ 10  

### Part 1: Literature Review .................................................................................... 11  
Abstract ................................................................................................................... 12  
Introduction ............................................................................................................. 13  
  The need for interpreters in health care ................................................................. 13  
  Models of interpreting in mental health ................................................................. 14  
  Interpreting in mental health contexts ................................................................. 15  
  The experiences of interpreters .......................................................................... 16  
  Review Aims ......................................................................................................... 17  
Method ..................................................................................................................... 17  
  Critique of approach ............................................................................................ 17  
  Search Strategy .................................................................................................... 18  
  Data extraction .................................................................................................... 19  
  Analysis ............................................................................................................... 19  
Results ..................................................................................................................... 21  
  Overview of studies ............................................................................................. 21  
  Systematic thematic analysis ............................................................................. 28  
    Theme one: Mental health interpreting is an enhanced role ............................ 28  
    Theme Two: Bearing Witness ........................................................................ 30  
    Theme Three: Emotional Impact .................................................................... 31  
    Theme Four: The Relationship Matters ......................................................... 33  
    Theme five: Coping (trial and error) ................................................................. 35  
Discussion ............................................................................................................... 37  
  Key Issues for Mental Health Professionals ....................................................... 38
Recommendations for Mental Health Services .............................................. 39
Limitations ...................................................................................................... 40
Conclusion ..................................................................................................... 40
References .................................................................................................... 41

Part 2. Research Report ................................................................................ 48
Abstract ........................................................................................................ 49
Introduction .................................................................................................... 50
Polish individuals and the Social Context ...................................................... 51
Psychological Effects of Moving to the UK ..................................................... 51
Accessing Psychological Support .................................................................. 52
Implications for Clinical Psychology practice ................................................. 52
Research on role of interpreters in mental health .......................................... 53
National Guidelines ........................................................................................ 55
Professional identity and role of the interpreter ............................................. 55
The current study .......................................................................................... 56
Research aims and research questions .......................................................... 57
Methodology .................................................................................................... 58
Research context ............................................................................................ 58
Interpretative Phenomenological Analysis (IPA) .......................................... 58
Reflexivity ...................................................................................................... 60
Method ............................................................................................................. 60
Ethics .............................................................................................................. 60
Participants ................................................................................................... 61
Recruitment ................................................................................................... 61
Inclusion / Exclusion Criteria ......................................................................... 61
Sample Size ................................................................................................... 62
Materials ........................................................................................................ 62
Procedure ...................................................................................................... 63
Analysis of Results ......................................................................................... 64
Methods to Enhance Quality ......................................................................... 65
Results ............................................................................................................. 66
Theme 1: Just a linguist? .............................................................................. 69
Appendices ................................................................. 118
*Appendix A: Guidelines to authors for journal targeted for literature review 119
Appendix B: Inclusion/exclusion criteria .......................................................... 123
Appendix C: Table 1 showing results of 10 searches .................................... 123
Appendix D - Shortlisted papers which were excluded .......................... 125
Appendix E: Data Extraction Proforma ......................................................... 128
Appendix F: Description, critical appraisal and synthesis ......................... 129
Appendix G: Thematic Synthesis (overview) ................................................ 130
Appendix H: Overview of each included paper ............................................. 131
Appendix I: Thematic Analysis: Breakdown of themes per article ........... 135
*Appendix J: Statement of epistemological position .................................. 136
*Appendix K: Letters to and from University ethics committees ............... 137
*Appendix L: Notification of Sponsorship from University of Leicester .... 138
*Appendix M: Letters to and from NHS R & D committees ....................... 141
Appendix N: Additional ethical considerations ........................................... 146
Appendix O: Topic Guide ............................................................................. 148
*Appendix P: Participant Information Sheet ................................................ 150
Appendix Q: Written Consent Form .............................................................. 153
Appendix R: Voucher Receipt form ................................................................. 154
Appendix S: Example of Initial Analysis ......................................................... 154
*Appendix T: Chronology of research progress ........................................... 156

* Mandatory Appendix

Appenda: Transcripts have been separately presented as an Addendum
Transcript 1: ‘Natalia’
Transcript 2: ‘Marta’
Transcript 3: ‘Zofia’
Transcript 4: ‘Lena’
Transcript 5: ‘Pawel’
Transcript 6: ‘Kristoff’
## List of Tables

**Part one: Literature Review**

Table 1: Summary of the Eleven included papers  
Page Number  
24-27

**Part two: Research Report**

Table 1: Overview of participant’s experience working  
as an interpreter in the NHS.  
Page Number  
62

Table 2: Overview of super-ordinate and subthemes  
67

Table 3: Use of notation in participant quotations  
69
This paper has been formatted to take into account the International Journal of Culture and Mental Health author guidelines but has exceeded the maximum number of words allowed for this journal (see Appendix A). This literature review has been written in line with the DClinPsy thesis requirements.
How do interpreters experience their role when working in mental health settings? A systematic review

Colm Gallagher

Abstract

Purpose: The literature in relation to working with interpreters in mental health is limited. The aim of the current review was to provide a thematic synthesis of the research literature in relation to the experiences of professional interpreters of migrants within a mental health context.

Methods: A systematic review of the literature was carried out. Literature searches were conducted in ‘Psychinfo’ and ‘Web of Science’. Of the 1805 articles found, eleven met the inclusion criteria for the review (studies reporting on the experiences of interpreters in mental health settings since 2000). The process followed Thomas and Harden (2008) recommendations of data collection, critical appraisal and synthesis.

Results: The majority of studies (n = 8) focussed on interpreters of refugees and asylum seekers; two papers focussed mainly on refugee and asylum seekers but included other migrants and one paper did not give this level of information. The majority of studies were based in the UK (n = 7), with two from both Denmark and USA. In total, five themes were uncovered. These were ‘mental health interpreting is an enhanced role’, ‘bearing witness’, ‘emotional impact’, ‘relationship matters’ and ‘coping (trial and error)’.

Conclusions: The literature purported to show the added complexities of interpreting when compared to other health settings. This included the differing expectations of clinicians, interpreters own professional guidelines and the working alliances within sessions. Interpreters can be emotionally affected whilst working in mental health settings. This can relate to bearing witness to traumatic accounts which can cause distress and affect their wellbeing. Continuity of working with both clinicians and clients is beneficial, if interpreters are appropriately supported.
**Introduction**

Interpreters play a vitally important role in helping migrants (asylum seekers, refugees, economic and ‘undocumented’ migrants) gain access to mental health services. The role of the interpreter is set to grow in importance as, globally, the number of individuals living outside their country of birth is increasing. In 2013, an estimated 232 million people (3.2% of the world’s population) were international migrants (United Nations, International Migration Report, 2013). In the UK, net migration was at 298,000 in the year ending September, 2014 (Office for National Statistics, 2015). According to the systematic review of Fazel et al. (2005), 1 in 10 refugees could be said to have post-traumatic disorder, 1 in 25 a generalised anxiety disorder and 1 in 20 suffer from major depression. Given these assumptions, it is clear that some of those who migrate to the UK may need the support of mental health services.

**The need for interpreters in health care**

Migration to the UK is an important part of the country’s history. The British Commonwealth, the world wars, being a member of the European Union and a signature of the 1951 Refugee Convention all play a role in individuals coming to the UK. By the end of 2014, the number of applications for asylum increased by 34%, compared to the previous year. The majority were nationals of Eritrea and Pakistan (Home Office, 2015). Polish immigrants remain the largest group of economic migrants to the UK.

The mental health needs of migrants are frequently identified in Department of Health reports (Department of Health, 2010). It is generally acknowledged that different migrant groups will have different personal experiences and requirements from mental health services. Asylum seekers and refugees, for example, are often fleeing persecution, disaster, violence or disease and therefore may have a greater risk of serious mental health problems.

There are a number of challenges to health services delivering care to migrants. Providing effective communication can be difficult due to language
barriers and cultural differences. Effective communication is necessary for the provision of good quality health care. Without this, it is difficult for the service to meet the client’s needs. Many immigrants can experience barriers to accessing health and mental health services. This can be due to not understanding that services are available, not knowing how to access them or confusion around entitlement to NHS care (Department of Health, 2010). Interpreters play an important role in facilitating the process of communication between the client and the service provider.

Models of interpreting in mental health

Westermeyer (1990) describes three models of interpreting: the triangle model, the black box model and the bilingual worker model. The triangle model involves all three individuals (therapist, interpreter and client) involved in the consultation. This model places greater demands on the clinician who keeps both the interpreter and client in mind. This model promotes a co-working relationship between interpreter and therapist. The therapist observes both the client and interpreter, paying attention to their emotional reactions to the consultation. This model requires trust between the therapist and interpreter and an understanding of their respective roles. Miller et al. (2005) found that most therapists and interpreters spoke of understanding the interpreting role in relational terms. In some cases, the interpreter forms part of a triadic alliance and may be considered a “bicultural worker” (Tribe and Lane, 2009). The role of a “bicultural worker” is described as requiring an understanding of the cultural, social and linguistic variables of a client’s difficulties and the mental health setting within which the work takes place (Tribe and Lane, 2009).

Westermeyers’ (1990) second model is the ‘black box’; the interpreter works as a ‘translation machine’, who takes messages from therapist to client and client back to therapist. This model supposes the interpreter does not have a clinically significant relationship with the client. It may also be seen as reducing the complexity of the translation and the demands of interpreting (Westermeyer, 1990). The third model is that of the bilingual worker which
requires the interpreter to also have a clinical role, meaning a dyadic relationship is developed between the clinician and client. However, too few clinicians working in the UK mental health services are bilingual (Tribe & Raval, 2003).

Interpreting in mental health contexts

The literature in relation to working with interpreters in mental health is limited. Tribe & Thompson (2009) suggests that therapeutic working in mental health settings with interpreters is viewed more negatively than warranted by mental health professionals. Lack of understanding of each other's role, and clinician anxiety may affect therapeutic outcomes for clients (Tribe & Raval, 2003).

Mental health services are reliant on self reporting, either through psychiatric consultation or talking therapies. Language is central to the process but language is fraught with ambiguity, can be misinterpreted and have unthinking assumptions (Payne, 2006). When one speaks, the listener may accept what is said as true without being aware of the unstated premise or belief of either himself or the speaker. Nuances of language can change meaning and therefore how experiences are conveyed. Language is the result and shaper of historical and culturally derived meanings which can influence or distort the very characterisation of experience between a client, interpreter and mental health professional. This makes the role of the interpreter more complex than initially thought. Previous research also suggests that without formal interpreting training, error rates in interpreting are likely to be more common (Karlner et al., 2007; Searight and Armock, 2013).

Tribe (1998) discusses the process of a five year long group clinical supervision for interpreters. This reflective paper acknowledges how interpreters are the ones that first hear the client’s words and emotions. Interpreters need to process this information emotionally and to find meaning for themselves to interpret for the clinician (Tribe, 1998).
Raval (1996) noted when therapists work cross culturally, having additional help in understanding the client’s cultural background is important. An interpreter is someone who can help with this. However, as Patel (2003) notes, interpreters may ‘feel obliged to offer cultural interpretation’ which may not be accurate from the client’s point of view. Therefore, it is important for clinicians to be aware of these issues and to have clinical responsibility within their work with interpreters.

The experiences of interpreters

One of the most recent reviews looking at interpreters in health care settings was Brisset et al. (2013). This was a systematic review and meta-ethnography of qualitative studies to identify relational issues involved in working with interpreters in healthcare settings. The study found that in healthcare settings the interpreter fills a wide variety of roles which can be a source of tension but also have relational opportunities in the consultation. Clinicians may sense a loss of control or power over the consultation. In order to overcome this, trust and respect between interpreter and clinician is an important factor in finding a constructive relational dynamic.

Brisset et al. (2013) also uncovered ‘difficulties’ as a theme. This referred to difficulties encountered which relate to issues of trust, control and power. Trust and control issues take place within the relational dynamics between the interactions of patients, interpreters and practitioners.

The review also noted trust and control as being expressions of power struggles occurring in broader contexts such as healthcare, or political decisions affecting minority voices. The final theme emerging from the review was ‘communication characteristics’, stating the non-literal translation appears to be a prerequisite for effective and accurate communication. The study called on more research into how relational issues in interpreted interactions affect patient health care.
Review Aims

The aim of the current study is to systematically review the research literature in relation to the experiences of interpreters in mental health settings. The review seeks to provide a thematic synthesis to the findings in previous qualitative studies and to provide a platform for understanding the research undertaken within this topic area. This may help clinicians with limited experience of working with interpreters and mental health services in providing efficient and effective services to individuals with limited understanding of the English language.

Method

A systematic review of the literature was carried out in order to provide a synthesis of the existing themes and findings. An initial scoping exercise was initiated to determine the extent of the literature related to the topic area. This initial exercise aided the formation of the research question. The review aimed to focus on interpreters working with migrants within a mental health context, excluding interpreters of British Sign Language (BSL) for individuals with hearing impairments. This was felt to be beneficial to the focus of the review, as interpreters for individuals with hearing impairments may have experiences specifically related to their client group. Many of those in the deaf community may not have had the experiences of moving from one country to another. In addition, those individuals who are deaf and migrated from one country to another would have experiences which would be influenced by their disability. Therefore, the experience of interpreters of BSL may be different to interpreters of migrants. The process followed Thomas and Harden (2008) recommendation of data collection, critical appraisal and synthesis.

Critique of approach

Methods for reviewing literature of a qualitative nature in a systematic way are relatively new. There is still much ongoing debate and development to this emerging area of systematic review (Dixon-Woods et al., 2006 & Thorne et al.,
The benefits of systematically reviewing qualitative literature is that it provides a rigorous and explicit method in acknowledging the literature available on a chosen topic to provide reliable answers to the review question (Thomas & Harden, 2008). The approach to the present review is to conduct a thematic synthesis of the literature, which aims to produce an ‘aggregative synthesis’ with interpretative elements of the included findings (Dixon-Woods et al., 2006). This involves summarizing the data and generating concepts which emerge across the data into a developing theoretical structure (Dixon-Woods et al., 2006). This approach requires the reviewer to be reflective at all points in the process and to stay close to the data being reviewed.

Search Strategy

A search of two databases was conducted. These were ‘Psychinfo’ and ‘Web of Science’. An ‘all database’ search was conducted on the Web of Science databases. This included searches on the Web of Science core collection and Medline databases.

In order to produce the most systematic results, the same strategies and limits were applied to all databases. The search terms were developed to reflect the population (Interpreter, Language) and topic area of work (mental health, psycholog*, therapy, counsel*). An asterisk (*) was used to search for all variations of similar words with different suffixes and alternative spellings. Five groups of search terms were developed in line with the current review’s aim. These were ‘Interpreter and Mental health’, ‘Interpreter and Psycholog*’, ‘Interpreter and Therapy’, ‘Interpreter and Counsel*’ and ‘Mental Health, Interpreting, Language’.

The searches took place on 19th January, 2015. The inclusion/exclusion criteria and a breakdown of the search findings can be found in Appendix B/C. The searches were limited to articles published within the last 15 years and which are based in academic journals only. As can be seen in Appendix C, a total of 1805 articles were retrieved from the 10 searches conducted. An initial
screening exercise was carried out regarding the titles and abstracts. These were manually searched for relevance to the review question.

The literature search was deemed appropriate to cease when the same studies were repeating in the searches and no further potentially relevant studies were uncovered. Using the search strategies described, a total of 21 papers were examined further (see Appendix D). Of these articles, nine were found to meet the inclusion criteria and were included in the review.

A further two papers were uncovered in a hand search which included looking through citations and references of academic papers included from the electronic search. This brought the number of studies included in the review to eleven. The review is open to the possibility that other relevant studies relating to the research question have not have been included. However, the systematic search criteria aimed to limit this.

**Data extraction**

To ensure consistency a data extraction table was used to extract details of the studies. The table aided the reviewer to extract relevant information and findings in relation to the identified aims of the review (see Appendix E). Appendix F gives an overview of the Description, critical appraisal and synthesis process of the review.

It was noted that a number of the studies choose to focus, not just on the interpreters, but on wider factors such as mental health workers' opinions and experiences. For these papers, only the parts which directly related to the interpreter’s own experience were included in the current literature review.

**Analysis**

Thomas and Harding’s (2008) approach to thematic synthesis was utilised in the review. Thematic analysis is one of the most commonly used forms of qualitative research. It aims to examine and record patterns and themes within
the data (Braun & Clarke, 2006). Thematic synthesis forms three stages which can overlap (Thomas and Harding, 2008). This includes free line by line coding of the findings within each article’s results section, the organisation of these codes into ‘descriptive themes’ and thirdly, the development of analytical themes. As per Thomas and Harding (2008), only the results section of each paper is included into thematic synthesis. In addition, only those quotes or points made within each study which are shown to originate from interpreters’ own experiences are considered in the synthesis.

This methodology was used to uncover the emerging themes related to interpreters’ experiences of working in mental health settings. Due to the small body of research in this area, a thematic synthesis was felt to be the most appropriate method to highlight emergent themes across the literature. Thematic synthesis, which is based on a systematic review, is considered to be a rigorous and explicit method which enables the bringing together of the findings of primary research (Cooper and Hedges, 1994; Higgins and Green, 2006; Petticrew and Roberts, 2006). The process aims to present a true and as close an account as possible of the literature. The data analysis aimed to provide an aggregative review of the literature which was interpreted by the researcher who developed the names and content of each theme. The analytical process is described in Appendix G.

One limitation to this approach is that the findings of original studies are decontextualised. This proved problematic for the review as the data is pooled from different countries, health care systems and cultures. Themes are developed from different methodological and theoretical standpoints and may not be applicable to each other. The reviewer aimed to deal with these issues by constant checking and rechecking of data; having the analysis grounded in the data and self-reflection throughout the entire process. The reviewer reflected on the methodological integrity, representative credibility and analytic logic of the synthesis (Thorne, 1997).
Results

Eleven articles were deemed to meet the inclusion criteria and where included in the current literature review. A thematic synthesis was carried out on the elements of each paper which purported to describe and analyse interpreters’ own experiences when working in mental health contexts.

This section shall begin by providing a brief descriptive overview and critical summary of the eleven qualitative papers. To aide comparison, a more detailed overview of each study can be found in Appendix H. The second part of this results section presents a thematic synthesis of the findings from each study analysed.

Overview of studies

Of the eleven studies, eight focused on interpreters of refugees and asylum seekers (Butler, 2008; Miller et al., 2005; Holmgreen et al., 2003; Mirdal et al., 2012; d’Ardenne et al., 2007; Johnson et al., 2009; Splevin et al., 2012 and Green et al., 2012); two papers focussed mainly on refugee and asylum seekers but included other migrants (Doherty et al., 2010 and Resera et al., 2014) and one paper did not give this level of information (Becher & Wieling, 2014).

Seven studies were based in the UK (Butler, 2008; d’Ardenne et al., 2007; Splevin et al., 2012; Greet et al., 2012; Doherty et al., 2010; Johnson et al., 2009 and Resera et al., 2014), two were based in Denmark (Holmgreen et al., 2003 and Mirdal et al., 2012) and two were based in the USA (Miller et al., 2005 and Becher & Wieling, 2014). Only two studies focussed specifically on one ethnicity in their research (Holmgreen et al., 2003 and Green et al., 2012).

Regarding methodology, the most popular approach was Interpretative Phenomenological Analysis with four papers using this methodology (Johnson et al., 2009; Green et al., 2012; Splevin et al., 2012 and Butler, 2008); three papers used Grounded theory (Holmgreen et al., 2003; Doherty et al., 2010 and Resera et al., 2014); one paper used a narrative approach (Miller et al., 2005);
one paper used a phenomenological approach (Mirdal et al., 2012); one paper used a Ethnographic Developmental Research Sequence (Becher & Wieling, 2014). One paper was part of a service evaluation which did not disclose its methodology for analysis (d’Ardenne et al., 2007), which is a limitation to the study as it is unsure how the data was analysed. Table 1 provides a brief summary of each paper.

All studies were exploratory in their nature, which reflects the limited scope of the literature at the present time. There was no mention of data reaching saturation point in any of the literature. This is a limitation for the papers which use grounded theory (Holmgreen et al., 2003; Doherty et al., 2010 and Resera et al., 2014). IPA research does not aim for data saturation (Smith et al., 2009) and so was not an issue for Splevins et al. (2012), Johnson et al. (2009), Green et al. (2012) and Butler (2008). The findings in the present review are not generalisable to the wider context due to the limited nature of the literature available. However, the depth of knowledge provided in the literature thus far points to a fruitful analysis of the individual and collective experience of interpreters.

Bercher & Wieling (2014) interviews were analysed by more than one researcher; member checking and self-reflection occurred throughout the research process. One limitation was the difficulty in distinguishing between therapist and interpreter themes within the paper. The use of auditing and self-reflection by Splevin et al. (2012), aided the validity of the findings. The sample was biased to those interpreters who could cope with the role long enough to be interviewed.

Doherty et al. (2010) surveyed 157 interpreters and received a low 13% response rate. This may have led to bias in the results. It was also unclear if interpreters worked with refugees/asylum seekers and/or economic migrants. Holmgreen et al. (2003) had limited information regarding reflexivity of authors or inter-coder reliability within the analysis.
d’Ardenne et al. (2007) did not distinguish between comments made by interpreters themselves and the interpreting service manager. Interpreters may have given socially desirable answers due to their manager being part of the same focus group. There was no information given on the methodology used to analyse the focus group data. A small number of interpreters were included but formed a useful part in the development of protocols for the clinic.

The analysis of Johnson et al. (2009) was audited by a second researcher and themes were evidenced within the data. One limitation was the author’s difficulties in defining what ‘non-western’ interpreting actually means. Mirdal et al. (2012) gave no details regarding gender, age or amount of experience amongst the interpreters. However, strengths of the study were that details of the researcher reflection process were included, inter-coder reliability was discussed as well as the benefits and limitations of collecting naturalistic data.

Semi-structured interviews, carried out by Miller et al. (2005), took place in person and over the phone. There was no discussion on how the mode of interview influenced answers given. Inter-coder reliability was measured across researcher and taken into account in the final analysis. Green et al. (2012) provided an account of their ongoing self-reflection throughout the study and a process of auditing by an independent researcher.

Butler’s (2008) short paper provided little information on the author’s epistemological stance or inter-coder reliability. The exploratory study by Resera et al. (2014), using a grounded theory approach (Strauss and Corbin, 1990), reported on interpreters who work with ‘recent’ migrants, mainly refugees and asylum seekers. The study did not give details of data reaching saturation point. Due to word count limitations, only two of the five themes developed from the study were detailed in the paper.
Table 1: Summary of the Eleven included papers.

<table>
<thead>
<tr>
<th>Title of study</th>
<th>Author and Year</th>
<th>Aim</th>
<th>Setting (country and service setting)</th>
<th>Methodology</th>
<th>Methods</th>
<th>Main findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Intersections of Culture and Power in Clinician and Interpreter Relationships: A Qualitative Study.</td>
<td>Becher &amp; Wieling (2014)</td>
<td>Examining how interpreters and clinicians work together in delivering care.</td>
<td>Based in USA. Recruited from agency, working in diverse assortment of services.</td>
<td>Ethnographic Developmental Research Sequence (Spradley, 1980)</td>
<td>Semi-structured interviews with 10 interpreters. Purposive Sample.</td>
<td>3 main themes: Interpreter speaking out; The relationship matters; Who has the power?</td>
</tr>
<tr>
<td>How does it feel for you? The emotional impact and specific challenges of mental health interpreting.</td>
<td>Doherty et al. (2010)</td>
<td>Examine the impact of mental health interpreting on the well-being of interpreters.</td>
<td>Based in the UK. Agency based interpreters, working across range of services.</td>
<td>Grounded Theory Analysis (Pidgeon and Henwood, 1996)</td>
<td>Survey based semi-structured questionnaire. Convenience Sample of local Interpreting service (157 interpreters,</td>
<td>Over half of participants reported being emotionally affected by their work, experiencing emotions such as anger, sadness, hopelessness and powerlessness.</td>
</tr>
<tr>
<td>#</td>
<td>Topic</td>
<td>Authors (Year)</td>
<td>Methods</td>
<td>Setting</td>
<td>Findings</td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>----------------------------------------------------------------------</td>
<td>----------------</td>
<td>----------------------------------------------------------------------</td>
<td>---------</td>
<td>-------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Stress and coping in traumatised interpreters: A pilot study of refugee interpreters working for a humanitarian organisation.</td>
<td>Holmgreen et al. (2003)</td>
<td>Explore the working conditions of interpreters of a humanitarian organisation and the perceived difficulties and strains of their work.</td>
<td>Based in Denmark. 10 permanently employed participants and two freelance.</td>
<td>Grounded Theory (Strauss &amp; Corbin, 1990). Semi-structured interviews with 12 interpreters. Purposive Sample. Interpreters have a heavy workload and high level of distress; most distress when working with psychologists.</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Interpreters’ experiences of trauma: The protective role of culture following exposure to trauma</td>
<td>Johnson et al. (2009)</td>
<td>Exploration of how interpreters working in the UK who had formerly suffered trauma in their country of origin navigate the challenges of interpreting trauma-focused sessions.</td>
<td>Based in UK. Employment contracts – unknown.</td>
<td>Interpretative Phenomenological Analysis (Smith, 1996). Semi-structured interviews with nine interpreters. Purposive sample. Three key themes: trauma in the context of wider shared oppression; resisting and responding; cultural protection and growth.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Traumatized refugees, their therapists, and their interpreters: Three perspectives on psychological treatment.</td>
<td>Mirdal et al. (2012)</td>
<td>To study how traumatized refugees, their therapists and interpreters perceive both curative and hindering factors in psychological therapy.</td>
<td>Based in Denmark. Employment contracts – unknown.</td>
<td>Phenomenological Approach (Giorgi, 1985)</td>
<td>Semi-structured interviews with eight interpreters about specific cases they had worked with. Purposive sample.</td>
</tr>
<tr>
<td>9</td>
<td>Too close to home? Experiences of Kurdish refugee interpreters working in UK mental health services</td>
<td>Green et al. (2012)</td>
<td>Explore Kurdish refugee interpreters’ experiences of working in UK mental health services</td>
<td>Based in UK. All participants worked freelance.</td>
<td>Interpretative Phenomenological Analysis (Smith et al., 2009)</td>
<td>Semi-structured interviews with six interpreters. Purposive sample.</td>
</tr>
<tr>
<td>10</td>
<td>Speaking the unspeakable:</td>
<td>Butler (2008)</td>
<td>Investigates how interpreters make</td>
<td>Based in UK. Employment</td>
<td>Interpretative Phenomenological Approach</td>
<td>Semi-structured</td>
</tr>
<tr>
<td>Study Title</td>
<td>Methodology</td>
<td>Participants</td>
<td>Data Collection</td>
<td>Research Goals</td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------------------------------------------------------------------------</td>
<td>--------------------------------------------------</td>
<td>------------------------------------------------------------------------------</td>
<td>-----------------</td>
<td>--------------------------------------------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female interpreters' response to working with women who have been raped in war</td>
<td>Grounded Theory (Strauss &amp; Corbin, 1990)</td>
<td>Three interpreters.</td>
<td>Purposive sample.</td>
<td>Interview with three interpreters. Understanding of clients' responses to rape; understanding why rape happens; Avenues of support.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interpreting in mental health, role and dynamics in practice</td>
<td>Grounded Theory (Strauss &amp; Corbin, 1990)</td>
<td>12 interpreters in two separate charities.</td>
<td>Convenient Sample.</td>
<td>To analyse the dynamics of interpreter mediated psychotherapeutic encounters with migrants from the point of view of interpreters. Two semi-structured focus groups with a total of 12 interpreters. Mental health interpreting is atypical and can be overwhelming. Interpreters have many other layers of complexity within the conversational encounter, they frequently have to act as cultural and language brokers.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Systematic thematic analysis

It is beyond the scope of the review to present all findings emerging from the literature, and instead this section will focus on the most consistent commonalities and themes. Although each theme is distinct, a number of themes do overlap and are related to one another. From reading the results sections of each paper, five main themes emerged from the literature: ‘mental health interpreting is an enhanced role’; ‘bearing witness’; ‘emotional impact’; ‘relationship matters’ and ‘coping: trial an error’. A summary of which studies the themes emerged from can be found in Appendix I. A more detailed description of each theme is given below.

Theme one: Mental health interpreting is an enhanced role

This theme highlights the role of interpreting in mental health contexts, and in particular the differences compared to other interpreting settings; both within and outside of health care. Within this theme, a number of factors emerged including how there can be differing expectations and tensions when working with mental health workers, the interpreter becoming a therapy conduit and the importance of the working alliance.

Miller et al. (2005) described interpreters as having multiple roles; a view shared by Resera et al. (2014). Interpreters describe mental health interpreting as being on a ‘different level’, where ‘more involvement’ and experiences of empathy towards clients is perceived as helpful (Doherty et al., 2010; Mirdal et al., 2011; Splevins et al., 2012; d’Ardenne et al., 2007; Butler, 2008 & Holmgreen et al., 2003). Holmgreen et al. (2003) highlighted how interpreters do not get recognition of this involvement on a service level which can lead to distress and difficulties in their professional life.

Splevins et al. (2012) had a focus of post traumatic growth in their study. The interpreters described the added complexity of mental health work, one interpreter stated:
“You have to visualise, you know, when you do the interpreting; the interpreting process is not just about words. When you’re telling a story, it’s complex, it’s set in a place and you have to process all that. So you’re hearing the story but you’re also saying the story and imagining what it was like for the person. You know the emotions, they can never be as strong as what the client feels, but you get a sense of the way they might have felt” (Splevins et al., 2012, p.1709)

From this account, it is clear that interpreters are more than the ‘black box’ (Westermeyer, 1990), in a way they are retelling a story and putting themselves in the shoes of the client during the telling. The clients’ feelings are processed during this retelling by the interpreter.

Becher and Wieling (2014, p.5) highlighted how familiarity between clinicians and interpreters can empower interpreters in their role. This study contrasted onsite and agency staff’s experience of their role. Onsite interpreters spoke of having more opportunities to work with clinicians and feel ‘part of the team’ and could adjust their way of working with each provider. In contrast, agency interpreters were more likely to feel distance and discomfort in their role. In addition, agency interpreters described ‘getting the brunt of frustration’ from clinicians. The lack of working relationship may limit the level of comfort an interpreter has whilst doing his/her role. Interpreters can, at times, feel like ‘technical tools’ as described by Holmgreen et al. (2003). Interpreters can experience disrespect in their roles from clinicians and feel undervalued (Green et al., 2012).

Becher and Wieling (2014) discussed interpreters, at times, feeling empowered to speak out during their roles and at other times having their voice silenced. Reasons given for an interpreter doing more than interpreting included a

“commitment to their professional responsibility, seeing something go wrong (mistreatment of client), comprehension of client, or outcome of session), and acting as a cultural broker”. (Becher and Wieling, 2014, p. 4)
As one interpreter stated:

“Usually...I step out of my role and say “I’m stepping out of my role, I think you need to know this....This is what it means for us....” I do it right away, if it would take the conversation or the outcome of the conversation the wrong way”. (Becher and Wieling, 2014, p.4)

Some interpreters choose not to step out but doing so could lead to interpreters becoming frustrated, as they can identify with clients and see them as ‘losing’ out (Green et al. 2012).

Miller et al. (2005) described experienced interpreters as having the same core qualities of therapists; including a high degree of empathy, psychological mindedness and good interpersonal skills. In addition, Mirdal et al. (2011) stated good working alliances and interpersonal relations as being curative factors relating to client outcomes in psychotherapy with interpreters.

Theme Two: Bearing Witness

Five of the papers in the literature review discussed interpreters’ accounts of bearing witness to clients’ stories (Splevins et al., 2012; Johnson et al., 2009; Miller et al., 2005; Green et al., 2012 and Butler, 2008). Butler (2008) gives an account of interpreters distancing themselves as a defence:

“I find it almost surreal sometimes, difficult to relate, it’s not in my experience”. (Butler, 2008, p.24)

Splevin et al. (2012) discussed how interpreters spoke of shock at witnessing clients’ accounts of the trauma they endured. Bearing witness can lead to distress in the short term but can also help build the relationship between each member of the triad. Interpreters also spoke of how their own experience of trauma could help others (Johnson et al. 2009):
“There was a sense that it was helpful for them to think of their experience as having a useful purpose”. (Johnson et al., 2009, p.415)

An aspect related to bearing witness to the accounts of clients, was personal resonance when hearing, at least aspects, of client accounts. This often proved emotive and at times overwhelming for interpreters.

Some interpreters reported having flashbacks from interpreting sessions. They also identified with some of their clients which could result in “huge psychological pressure from work” (Holmgreen et al., 2003, p.25). d’Ardenne et al. (2007) mentioned that some interpreters fear re-traumatisation, having experienced traumatic events in their own lives. This was in line with Green et al. (2012) ‘too close to home’ theme, interpreters here acknowledge the benefits of having shared experiences (facilitates understanding) but also the problems (nightmares and flashbacks). One interpreter commented:

“I always hoped that people would not come from the same place or talk about the same things”. (Green et al., 2012, p231)

Resonating with clients can lead to the interpreter struggling with his/her emotions. Interpreters may need support in helping them to cope during these times.

Theme Three: Emotional Impact

All papers in the literature illuminated the emotional impact which interpreters can experience when interpreting in a mental health context. Holmgreen et al. (2003) stated that all interpreters reported severe emotional stress due to their roles. This related to feelings of frustration and powerlessness, and led to some interpreters leaving the profession by the time they were interviewed. Interpreters’ descriptions of the emotional impact could, at times, be overwhelming (Green et al. 2012; Johnson et al 2012; Splevins; Resara et al. 2014), and leave an emotional toll (Butler, 2008). Interpreting in mental health
settings can also be anxiety provoking and may potentially lead to interpreters re-experiencing their own trauma (Miller et al., 2005).

Interpreters who show their emotions within sessions can feel that it is “unprofessional” (Splevins et al. 2012). An interpreter from Miller et al. (2005) stated:

“I remember one woman who was raped and when she told me what happened I was crying. And I could not say anything so I had to wait until I stopped crying to translate. So the therapist could not know immediately what happened. So that was very hard and in that moment I felt like, it was not fair, I was weak. And after that I had a big discussion with the therapist and I realised it was not weakness, it is just a human reaction”. (Miller et al., 2005, p.34)

In other services interpreters do not feel empowered to ask for debriefs. Holmgreen et al. (2003) states how some interpreters experience a low level of recognition and respect, being badly treated. According to Green et al. (2012, p231) one interpreter states “I couldn’t control, I cried and then after that I stopped working that...because I now emotionally involved and I believe that part is wrong, so I can’t be impartial...”.

An interpreter in the study by Splevin et al. (2012) described how emotional involvement with clients could move from initial distress and shock to developing coping strategies and then, over a period of time, being able to manage distress. In line with this, continuously working with the same client could bring feelings of joy, happiness, hope and inspiration. This can be seen as mirroring the client’s emotions, and being a part of their journey. As one interpreter stated it could take “a few years” before “you see these people getting up again and saying life is good” (Splevin et al. 2012, p.1710).
Theme Four: The Relationship Matters

This theme, of the same title as a theme from Green et al. (2012), relates to the relationships between interpreter, clinician and client within the therapeutic triad. Each paper alluded to the importance these relationships have had, not only on the interpreters themselves, but also for clients’ therapeutic outcome. This theme is made up by areas such as the relationship between the interpreter and clinician; the interpreter and client; boundary keeping; importance of trust and cultural knowledge and brokerage.

Becher & Wieling (2014) discuss the dynamic nature of relationships and how familiarity plays an important role in their development. Adjunct to this is power within these relationships and how this is negotiated between clinicians and interpreters. The less experienced and familiar an interpreter is to mental health services and individual clinicians, the less power they perceive to have (Becher & Wieling, 2004). Mirdal et al. (2012) describe how interpreters see the relationship as being a key element with regards to positive therapeutic outcomes. Interpreters in this study spoke of teamwork, which is respected, warm and welcoming as being a curative factor in therapeutic outcomes. As one interpreter put it “That the three of us were like a family” (Mirdal et al., 2012, p.451).

Holmgreen et al. (2003) highlights the frustration, low level of recognition and respect from clinicians by not ‘humanising’ the interpreter, treating them instead as “technical tools”. A survey by Doherty et al. (2012) uncovered that, for some interpreters, misunderstandings with clinicians and blaming interpreters for poor communication were seen as challenging aspects of their role. In contrast, in the same study, some interpreters viewed professionals showing appreciation for their work, being asked to return to the next appointment as being rewarding aspects of their role.

The interpreters interviewed in Splevin et al. (2012) described a process of identification with clients. The theme “feeling what your client feels” uncovered how interpreters spoke of having a strong sense of empathy with their clients.
This can help them to understand their clients, but also lead to distress, feeling overwhelmed, hopeless and deep sadness.

Butler (2008) discussed how interpreters may draw on their own lives to understand clients’ responses to trauma. Similarly, Green et al. (2012) and Holmgreen et al. (2003) described how interpreters use their own experiences in order to help clients, a factor which motivates them in their role. Miller et al. (2005) spoke of connecting with the client:

“…these people, when they come here, they have all these fears and anxiety and many of them have depression and PTSD. As interpreters, we are somebody they are connected to because they feel, ‘ok this is the person I should hold onto because she is helping me, she is interpreting for me, and whenever something happens she is the person that I run to, whether I call or go or something” (Miller et al., 2005, p. 31)

This connection can influence the interpreter’s role of being the therapy conduit and normalising therapy for clients. Interpreters can form empathic and reassuring connection with distressed clients. The interpreters also have a number of ways to manage difficulties within and outside sessions. They typically set boundaries with clients, avoiding them outside of the session. However, this could lead to interpreters being perceived as “cold” by clients (Green et al., 2012).

Clients could put unrealistic expectations upon interpreters (Miller et al., 2005). Boundaries could be challenged, during times of hardship. Clients may ask interpreters for something to be hidden from the clinician or attempt to have interactions outside the room (Resera et al., 2014).

Miller et al. (2005) spoke of the importance of trust, given that refugees can have a history of persecution and trauma. Therapy asks the clients to reveal experiences of loss, humiliation, oppression and victimisation to the interpreter and clinician.
Trust in the interpreter also relates to conveying an accurate message, when this is achieved the client can feel at ease to disclose in the therapeutic setting (Resera et al. 2014).

“Without the trust they’re not going to pour out...trust is extremely, is probably crucial in the situation.” (Resera et al. 2014, p.10)

The literature highlights how interpreters can be asked to provide cultural knowledge and guidance to therapists, which links into the therapy conduit role of the interpreter (Green et al., 2012; Holmgreen et al., 2003; Miller et al., 2005; Johnson et al., 2009; Doherty et al., 2010; Resera et al., 2014), particularly when therapy is seen as alien or viewed negatively in some cultures (Miller et al., 2005).

Interpreters bring cultural knowledge into the session. The theme of Green et al.’s (2012) – of negotiating multiple identities - highlights the clashing culture between UK mental health services and Kurdish cultural norms. An example of this was negotiating cultural differences in relation to privacy. A number of interpreters, according to Green et al. (2012), felt uncomfortable knowing details of people’s private and intimate lives, particularly in relation to rape, mental health issues and domestic violence, which are seen as highly sensitive in Kurdish culture.

Theme five: Coping (trial and error)

This final theme relates to interpreters’ reactions to the difficulties they face in session. The literature which covered this theme focused on strategies, rewards, defences, longer term benefits and support within their professional or personal systems (Butler, 2008; Miller et al., 2005; Holmgreen et al., 2003; Resera et al., 2014; Doherty et al., 2010; Johnson et al., 2009; Splevin et al., 2012 & Green et al., 2012).

Splevin et al. (2012) discussed how strategies to cope are unique to individuals. External support included friends and family, maintaining a good work-life
balance, counselling, debriefing with the clinician before and after sessions, peer supervision and employer support. Other examples of limiting mental health jobs, setting boundaries, distraction, social support (informal), and recognising the limits of their role were seen as helpful coping strategies (Splevin, 2012; Doherty et al., 2012; Butler, 2008; Holmgreen et al., 2003). Interpreters spoke of the importance of coping in order to recharge and carry on with the work (Green et al., 2012).

Over time interpreters spoke of “getting used” to therapeutic sessions and the painful stories discussed. The process was described as “lengthy” by Splevin et al. (2012). Rewards for doing this were seeing the clients become more positive and getting a sense of helping them through their journey. Green et al. (2012) also spoke of interpreters being surprised by their emotional reactions and not being prepared for the impact but experience helped with this (Green et al., 2012; Miller et al., 2005).

Butler (2008) spoke of the concern of the lack of support from employers:

“It’s all supposed to be a certain way when you study interpreting, then when you are in the field it’s not all as thorough as that because of time constraints or people just can’t be bothered or they just don’t know”. Butler (2008, p.24)

This theme was also picked up by Doherty et al. (2012) when some interpreters avoided mental health work or felt that they got an inadequate remuneration for the demands of their role. Interpreters also spoke of feeling like they are in a precarious position, of “little status, low pay, little respect and minimal training and support” (Green et al. 2012 p.231). Interpreters, from the studies of Green et al. (2012), feel this may be because service providers underestimate the impact of the work and the emotional impact this has on interpreters themselves.
In the literature, interpreters spoke of a sense of change in themselves. One theme discussed by Splevin et al. (2012) was that of becoming a different person:

“…and there’s alot of strength, vulnerabilities, weakness, a lot of emotion involved in all of this, and I have to analyze it for myself, and by analysing it, I have become a wiser person maybe, and this is quite satisfying to myself.” (Splevin et al., 2012, p.1711)

Some experienced interpreters alluded to changes in their life priorities, an emphasis on relationships, compassion, being more open and intimate, feeling valued, wiser, and “living in the moment” (Splevins et al., 2012 p.1711).

Discussion

The aim of the current review was to provide a thematic synthesis to the findings of previous qualitative studies relating to the experiences of interpreters of migrants in a mental health context. Eleven articles were deemed to meet the inclusion criteria and where included in the thematic synthesis. In total, five themes were developed; these were ‘mental health interpreting is an enhanced role’, ‘bearing witness’, ‘emotional impact’, ‘relationship matters’ and ‘coping (trial and error)’.

The literature purported to show the added complexities of interpreting in a mental health context when compared to non-mental health setting. This included the differing expectations of clinicians and the triadic therapeutic alliance within sessions. Interpreters can be affected emotionally whilst working in mental health settings, this can relate to bearing witness to traumatic stories which can cause distress and affect their wellbeing. Most interpreters involved in the studies of Miller et al. (2005) reported how distress may be short lived, provided the appropriate support is available. This support may include debriefs following sessions and supervision for ongoing work. Continuity of working can foster positive emotions in interpreters (Miller et al, 2005; Resera et al. 2014; Becher & Weiling, 2014), which can be beneficial to the work.
In relation to Westermeyers’ (1990) description of the three models of interpretation, the literature purports to show that the interpreters are engaged in a triangular model of interpreting. The interpreters are more involved than simply being a ‘black box’, a resource for passing messages back and forth between clinicians and clients. Within the triangular model, interpreters can be emotionally impacted as they bear witness and develop humane relationships with clinicians and clients.

Miller et al. (2005) found that most therapists and interpreters spoke of understanding the interpreting role in relational terms. Whereas Holmgreen et al. (2003) discuss how interpreters are disrespected with their needs not taken into account. One reason for this perceived disrespect could be that some organisations and/or clinicians view the interpreter as per Westermeyer’s (1990) ‘black box’, as a linguist only with no emotional involvement in their role. Many factors determine how interpreters and clinicians work, familiarity of roles and trust appear to be two important factors as discussed by Mirdal et al. (2012). These are shown by Mirdal et al. (2012) to have a therapeutic benefit to client outcomes.

The research shows that interpreters build relationships with clinicians and clients. They can also bridge the gap in knowledge between the different cultures they experience. In doing so, they bear witness to the accounts which have led clients to mental health services. Their personal experiences may resonate with clients’ stories which, at times, can be overwhelming. There are benefits to the role, in the form of helping others but interpreters do not always feel they are supported in their employment.

**Key Issues for Mental Health Professionals**

Mental health professionals have the clinical responsibility within sessions when working with interpreters. Open acknowledgement of the complexities working in mental health should be encouraged by mental health clinicians. This could take the form of offering to co-ordinate support, including clinical supervision, time for briefing/debriefing at appointments. Furthermore,
education in mental health services for both interpreters and mental health professionals on how to work best together would aid mutual understanding. Such work could be facilitated by mental health professionals.

The review also highlighted how interpreters can bring specific cultural knowledge to their role. There were a few specific examples given in the literature of interpreters sharing important information with clinicians. Holmgreen et al. (2003) showed how interpreters recognise and share information regarding the difference between Danish and Albanian cultures. Mirdal et al. (2012) found that helping clients with information on life in Denmark can be a curative factor in therapy. Mental health professionals should be encouraged, when appropriate, to accept the limitations of their knowledge of specific cultures and work with interpreters and clients to further their understanding in order to aid the therapeutic process.

Recommendations for Mental Health Services

The enhanced role and responsibilities of interpreting in mental health settings requires specific case preparation, shared knowledge and clarity of roles (Raval, 1996). In order for interpreters to carry out their roles effectively they require prior knowledge of what is expected of them. Mental health and interpreting services should take this into account prior to appointments, giving both clinician and interpreter available space and time to discuss clinical work.

Interpreters can have negative emotional reactions to the accounts they interpret for. These are normal responses to hearing, at times, traumatic accounts from clients. Mental health professionals go through intense training and have supervision to cope with the demands of the job. Interpreters should have basic training of how mental health services operate. In addition, they may benefit from having support mechanisms in place. These can include mandatory briefing and debriefing sessions with clinicians and peer or group supervision on a regular basis.
The attrition rate of interpreters in services is unknown. It is unclear how many interpreters leave the profession or choose not to work in mental health settings due to the emotional impact. It would be beneficial for services to understand what the attrition rate is for those who interpret for migrants, asylum seekers and refugees in a mental health context; the reasons for them leaving the profession and the long term costs of staff turnover. More research, interpreter service evaluations and audits would be beneficial to discover the cost of attrition rates and may uncover cost effective ways of employing interpreters.

Limitations

The findings in the present review are not generalisable due to the limited, exploratory nature of the literature available. However, the depth of knowledge provided in the literature thus far points to a fruitful analysis of individual experiences of interpreters. This review is also limited in terms of studies taking place in a wide range of health care settings. It is difficult to compare NHS settings in the UK to other health care systems in the USA and Denmark and how this impacts on the interpreting role. The literature is also biased in terms of not including interpreters who have left their roles, or who have chosen not undertake mental health work. This limits the findings in relation to specific mental health services.

Conclusion

Globally, migration is increasing. In the UK, migration is a focal point for political parties and mainstream media to deflect the general public's attention away from wider social problems caused by neo-liberal policies. Such policies relate to moving the control of economic factors from the public ownership to the private sector operatives (Harvey, 2005). This has led to rising inequality of wealth within the UK. Inequality of wealth has been shown to increase anxiety and illness whilst encouraging excessive consumption and eroding trust in communities (Wilkinson & Pickett, 2009). The consequence of this deflection tactic is to dehumanise individuals fleeing war and persecution. For example, using words like ‘swarm’ to describe families who make life threatening
journeys to the Europe (BBC News, 2015) whilst ignoring the net economic benefit of migration to the UK (Dustmann & Frattini, 2014).

Migrants, particularly asylum seekers and refugees experience extreme hardship which can affect them emotionally. This timely literature review highlights the experiences of interpreters who can often be overlooked. Interpreters can experience distress due to their role, but also, with time and experience they may experience professional and personal growth. The majority of research in this area has occurred with interpreters of asylum seekers and refugees working in services. Less research has taken place in relation to economic migrants or migrants of a specific ethnicity (though Green et al., 2012 and Holmgreen et al., 2003 are exceptions). Future research in these areas may be of benefit to generic mental health services which have less contact with asylum seekers and refugees compared to economic migrants.

References


Part 2. Research Report
Exploring the experience of Polish interpreters who interpret for mental health professionals: An Interpretative Phenomenological Analysis

Colm Gallagher

Abstract

Objective: A gap was identified in the literature for research addressing interpreters of Eastern European economic migrants working in mental health settings within the UK. The research aimed to explore the experiences of Polish interpreters who interpret for mental health professionals and to understand how Polish interpreters view the triadic relationship between themselves, clients and mental health professionals when interpreting in a mental health setting.

Method: Six participants (four were female and two male) were recruited with each taking part in a semi-structured interview. Length of time working as an interpreter in the NHS ranged from 6 months to 10 years. Mental health formed only part of the participants paid employment within the NHS. Interviews were analysed using Interpretative Phenomenological Analysis.

Results: The participants’ accounts clustered around one superordinate theme of ‘being paid to be a machine for a human role’. This was made up of three themes: ‘Just a linguist?’, ‘Unspoken alliances’ and ‘Communicating emotional reactions’.

Conclusions: The findings of the current research emphasise that it is particularly important for clinicians, mental health and interpreting services to take into account the emotional impact and disempowerment caused by structural systemic factors which limit the voice of the interpreter. This study plays an important part in deepening our understanding of the interpreting process and how interpreters perceive the triadic relationship. Future research could focus on how the triadic relationship is developed and maintained by all three parties involved. Future research into how interpreters interpret the meaning of language and context in their role would also be fruitful by focusing the content in real life settings.
Exploring the experience of Polish interpreters who interpret for mental health professionals: An Interpretative Phenomenological Analysis

Introduction

Interpreters are used in many public services. They have an important role in facilitating communication between parties and are particularly important in mental health services. Burck (2004) showed how clients found speaking in their ‘mother tongue’, their first language, led to them feeling emotions that could be expressed more fully. Such communication is key to therapeutic change. Asking a client to communicate in their second language has the potential to create psychological distance from the therapeutic conversation and a feeling of separation from the therapist. In addition, if the person has difficulties communicating effectively, there is a risk of miscommunications occurring in the conversation which may be to the clients own detriment. Despite interpreters being exposed to significant client distress, little attention has been paid to the impact of mental health interpreting on the well-being of interpreters themselves (Doherty et al., 2010).

Tribe and Tunariu (2009) discuss how clinicians can view working with interpreters with ambivalence. One reason for therapists and wider mental health professionals viewing work with interpreters negatively may be due to their own anxieties and unfamiliarity of this type of work. Tribe & Keefe (2009) state that some clinicians who are unfamiliar with interpreters assume that effective work is not possible. Clinicians have reported feeling threatened by interpreters observing their work (Raval, 1996). One way to overcome this anxiety and unfamiliarity could be to understand how interpreters experience their role in mental health settings. Research investigating the role of interpreters who interpret in a mental health context is relatively sparse. The current research aims to help stakeholders understand how interpreters of the Polish language experience their role within NHS mental health services.
Polish individuals and the Social Context

In 2004, Poland along with seven other Eastern European nations joined the European Union (EU). Poland represented the largest group of migrants to the UK, with 71% of this new EU population who moved to the UK being of Polish nationality (Office National Statistics ‘ONS’, 2010). Home Office figures show there were 853,000 Polish individuals living in the UK in 2009 (ONS, 2015). Between 2004 and 2014 the number of Polish individuals residing in the United Kingdom increased by 784,000 (ONS, 2015).

Poland remains the largest foreign born national group living in the UK (ONS, 2015). In the year ending March 2014 the number of Polish migrants registering for a national insurance number was 102,000 (up 11,000 compared to the previous year). The highest number of new registrations for a national insurance number continues to be for Polish citizens, year on year (ONS, 2014).

It is difficult to get an overview of how the general public in Poland constructs mental health from academic literature. However, Poland uses the International Classification of Diseases (ICD-10). The Leksykon Psychiatrii (Lexicon of Psychiatric and Mental Health Terms) defines “psychological stress” in a similar way to that in the UK (Czabala et al., 2000). Mazur et al. (2012) identified medical students in Poland as holding negative stereotypes, in line with the general population, regarding those with mental health issues being a danger to society. The International Labour Organisation carried out a situation analysis into mental health within the work place in Poland (Czabala et al., 2000). The report described how public interest in mental health problems in Poland has been limited. This was described as reflecting political and social attitudes towards mental health.

Individuals in Poland with mental disorders are cared for by state health care facilities (Langiewicz & Slupczynsak-Kossobudzka, 2000), primarily under a public health care insurance company (National Health Fund). Primary care delivers care for a large proportion of non-psychotic mental disorders. However, these are described as unsatisfactory due to the inadequate
qualification of medical doctors (Langiewicz & Slupczynsak-Kossobudzka, 2000). The medical model predominates in therapy, though psychotherapy is available for individuals with neurotic disorders and alcohol dependence. There is ongoing work to base mental health services within the community (Langiewicz & Slupczynsak-Kossobudzka, 2000).

Psychological Effects of Moving to the UK

Weishaar (2008) conducted qualitative interviews with the aim of gaining a greater understanding of the personal experiences of Polish migrant workers who worked in manual and low-skilled jobs in Scotland. The study explored the impact of stress on physical and psychological health. Using a mixture of one to one interviews and focus groups the study found a number of factors which contributed to stress. These included difficulties with communication, and unfamiliarity with the new environment and culture. In addition, stress was reported in relation to work, performing practical, everyday tasks and duties, and the social aspect of living in a new country.

Accessing Psychological Support

Bassaly and Macallan (2006) conducted a thematic analysis of interviews with three polish female migrants in the UK. The analysis highlighted how accessibility and acceptability of psychological services were identified as important dimensions of willingness to seek psychological help. The study used self-report questionnaires and found Polish immigrants, who find it most difficult to access psychological services, are those who may reject British cultural values and are seen as being less resilient.

Implications for Clinical Psychology practice

In order for psychologists to meet the needs of migrant communities, an understanding of the role and experiences of interpreters is important. This understanding may facilitate working relationships when engaging with economic migrants in NHS settings. It is hoped that through understanding the
experiences of interpreters, the conditions of fostering trust and respect between co-workers involved with individuals unable to communicate in English can be achieved. Previous research suggests mental health professionals find it difficult working with interpreters (Raval, 1996). Few interpreters have had comprehensive mental health training which cover topics such as boundaries and self care. This may lead to the possibility of interpreters being susceptible to vicarious traumatisation (Tribe & Morrissey, 2003).

**Research on role of interpreters in mental health**

Tribe & Thompson (2009) suggests that interpreters can play a central role in the therapeutic relationship. Interpreters can act as a ‘cultural broker’, as language includes aspects of culture and the individuals world view (Holder, 2002). Tribe and Thompson (2009) also suggest that interpreters hold a symbolic value for clients. Interpreters can be a symbol of how far services and the clinician are prepared to go to meet and communicate with them. These experiences can be a powerful counterbalance to wider cultural and political narratives within the UK which can be seen as discriminatory towards immigrants. Raval (1996) reported how therapists felt more able to discuss racism and cultural differences with the presence of an interpreter. Tribe and Thompson (2009) suggest clinicians may be unsure in their working with interpreters due to their lack of experience, training and/or support.

Clinicians may feel that they are being scrutinised or may feel inferior to an interpreter due to the interpreter being more knowledgeable and familiar to the clients culture (Tribe & Tunariu, 2009). Patel (2003) suggests that mental health professionals may not fully realise that they and interpreters are mutually dependent in a number of ways, as the clinician needs the interpreters to translate for him/her. In turn, the interpreters need the words to translate, whilst both have a similar aim of wishing to alleviate distress for their client.

Habermasian theories have been used to understand communication in healthcare settings (Brisset et al., 2013). Greenhalgh et al. (2006) explored how two Habermasian tensions play out in healthcare consultation with
interpreters. These are a) Lifeworld and system; the lifeworld is where people exist and communicate to make collective sense of a situation and to develop a mutual understanding to provide a course of action (Habermas, 1987). The ‘system’ is described as the accumulation and administration which uses its own mediating forces, money and power (Habermas, 1987); and b) communicative and strategic action; communicative action is oriented to understanding within the lifeworld, whilst strategic action is where one party aims to produce an effect on others through speech, and is often orientated to success (Scambler et al., 2001).

Greenhalgh et al. (2006) found that the presence of an interpreter adds considerably to the complexity of the social situation. Issues around lack of trust, time pressures, mismatching of agendas and power imbalances promote strategic actions (which seek to manipulate outcome). This is at the expense of communicative action (efforts to achieve understanding and reach consensus). The study found that interpreters occupy multiple social roles, including being a translator, interpersonal mediator, system mediator, educator, advocate and link worker (Greenhalgh et al., 2006).

Tribe and Thompson (2009) describe the three way relationship in therapeutic settings with interpreters as being an ongoing process of splitting and pairing, which changes at different points in the therapy work. A number of factors affect these dynamics, including experiences of history, culture and similarity between clients and interpreters. These can be seen as helpful in relation to the therapeutic alliance (Raval, 1996; Saxthorph & Christiansen, 1991). At the same time, there may be commonality between the clinician and interpreter if the interpreter has assimilated into the dominant culture and/or taken on a professional identity in their work (Tribe and Thompson, 2009). This may lead to the interpreter identifying more with the therapist and distancing themselves from the client.

The power imbalances within the triadic relationship can affect outcomes but at the same time are ambiguous. The interpreters, as noted by Raval (1996), hold a strange position within health care organisations and services as they share
some skills similar to clinicians (listening, availability, and professional status) but they have little authority to take the lead in their work and are often employed under precarious employment contracts.

**National Guidelines**

Tribe and Thompson (2011) developed a number of guidelines for psychologists when working with interpreters. They state that effective working with interpreters should be a skill which all clinicians possess. This requires training and would lead to equal opportunities for groups who are considered ‘hard to reach’ for mental health services. A full account of the recommendations can be found in Tribe and Thompson (2011) and the BPS guidelines for psychologists using interpreters booklet (Tribe and Thompson, 2008).

Interpreters also have various sets of guidelines, depending on the organisation they work for. The National Register of Public Service Interpreters (NRPSI) issued a code of professional conduct in 2011. This was not specific to mental health settings but did have the following guideline for interpreters

“5.9 Practitioners carrying out work as Public Service Interpreters, or in other contexts where the requirement for neutrality between parties is absolute, shall not enter into discussion, give advice or express opinions or reactions to any of the parties that exceed their duties as interpreters”. (Page 5. NRPSI Code of Conduct)

The important aspect of this guideline is the advice of not having ‘reactions’ to the parties they interpret for. For a mental health and psychological therapy context, this guidance seems particularly problematic when the content of the work is emotional distress.

**Professional identity and role of the interpreter**

There have been a number of studies which highlight the importance of working
with a qualified interpreter as opposed to untrained or ad hoc interpreters such as other medical staff or family members (Bischoff et al., 2003; Eyton et al., 2002, Farooq & Fear, 2003; Tribe & Raval, 2003). Karliner et al. (2007) found that professional interpreters generally make fewer errors in translation and also have greater satisfaction amongst patients and practitioners.

Social identity theory (SIT) (Tajfel & Turner, 1986) and Self-categorisation Theory (SCT) (Turner et al., 1987) may be relevant to interpreters if they experience themselves as distinguished from other professional healthcare groups and whether they compare themselves favourably or unfavourably to other groups (including clients). As can be seen from the literature review carried out in part one of the thesis, interpreters do not see themselves as having the same status or power when compared to mental health professionals. Both SIT and SCT theorists suggest that use of professional identity and social categorisation are attempts to understand their environments and react to it.

Categorisation is the process of ‘arranging’ the social surrounding we find ourselves in, in order to understand it. Identification is the idea that we are close to certain groups which we feel we belong to. This can lead to ‘in’ group vs. ‘out’ group thinking; members of the ‘in’ group being similar in some relevant way (Turner, 1987).

Research has shown that effective communication can be hindered between healthcare employees due to their professional group membership (Soothill et al., 1995). An individual’s personal identity and social identity are influenced by many factors such as family or community roles. The workplace is one such key influence on how we perceive ourselves and how we are perceived in terms of identity, the roles, characteristics and attributes attached to us.

**The current study**

Under UK and European law, fluency in English should not be a barrier to accessing psychological services in the UK (Tribe, 2004). Interpreters
employed by the NHS are often on zero-hour contracts, employed for their time spent within appointments only. Mental health settings can be difficult to interpret in due to the information disclosed by clients, which may include accounts of abuse, trauma, neglect and oppression. Previous research with interpreters highlights how interpreters can be emotionally affected by what they interpret in their role (Miller et al., 2005). The majority of previous research relates to interpreters who have previously been asylum seekers who interpret for other asylum seekers and refugees.

The current study differs from previous research as it specifically focuses on interpreters of economic migrants within the NHS service. The study follows on from qualitative studies such as Green et al. (2012) and Miller et al. (2005). Green et al. (2012) conducted interviews with Kurdish interpreters, given refugee status, who worked in a mental health context in the UK. The USA based study by Miller et al. (2005) looked at the role of interpreters’ working in psychotherapy appointments. Thirteen of the fifteen interpreters interviewed in Miller et al. (2005) were refugees who came from Eastern European countries. The present study was developed from recent literature reviews carried out in relation to interpreters which called for further research into how relational issues in interpreted interactions affect patient care and health (Brisset et al., 2013; Searight & Armock, 2013). The study focuses on Polish interpreters as Polish individuals are the most common non-British nationality within the UK (ONS, 2015).

Research aims and research questions

The research aims to explore the experiences of Polish interpreters who interpret for mental health professionals. Choosing to focus how interpreters understand their role and the relationships within sessions, notably between themselves, clients and mental health workers.

The aims are:

- To understand how Polish interpreters experience their roles in translating in adult mental health settings.
To understand how Polish interpreters interpret the triadic relationship between themselves, clients and mental health professionals when interpreting in a mental health setting.

**Methodology**

**Research context**

A qualitative approach was used for the current research as there is currently a lack of research looking at the lived experiences of interpreters in general. Qualitative methodologies aim to develop an enriched and conceptual understanding of the experience of individuals. The chosen methodology is particularly suited to exploratory research, as it can elicit in-depth data within individual accounts (Lyons, 2000) and was deemed appropriate to the aims of this research.

Rather than comparing groups and categorizing behaviours, it is the intention of the current study to concern itself with the meaning associated with the lived experience of the interpreter. This will lead to the individual's perspective being explored and insight gained into their lived experience of working within a mental health context. A qualitative approach can facilitate the holistic, open nature of the research questions and facilitate an exploration into how the interpreters themselves understand their role and the process of interpreting within a mental health context, the emotions involved and how the nuances of the therapeutic interaction are interpreted and translated.

**Interpretative Phenomenological Analysis (IPA)**

IPA is proposed as the most suitable qualitative methodology to inform data collection and analysis. IPA is concerned with an individual's lived experience and its meaning to them (Smith, 2004).

Smith and Osborn (2008) describe IPA as not strictly a methodology but rather an approach that is guided by a particular ontology and epistemology.
Ontology is the nature of reality and how we can understand it (Hudson and Ozanne, 1988). Epistemology can be defined as the relationship between the researcher and reality (Carson et al., 2001) or how reality is captured or known, in other words what constitutes valid knowledge and how can it be obtained.

IPA represents a way to think about and to conduct research based on three central theoretical underpinnings; phenomenology, hermeneutics and ideography. The strength of this approach is that interpreters experiences can be explored in their own terms rather than according to predefined categories or others perceptions.

Phenomenology is a philosophy concerned with the study of experience. It places an emphasis on exploring the participants’ experience of a phenomenon, what the experience of being human is like in relation to a particular phenomenon (Smith et al., 2009). IPA is concerned with the meaning for the participant and the researcher.

Hermeneutics is a theory of interpretation of the participants own meaning-making whilst recognising the researcher’s central role in interpreting those meanings (Smith, 2004). In doing so, the researcher is mindful and transparent of his own preconceptions and bias’s which may influence such interpretations. Therefore, IPA employs a double hermeneutic, the researcher’s interpretation of the participants verbal record of their experience. The current study proceeded on the epistemological assumption that whilst an individual’s account of their experience can reflect their internal world in a meaningful way, this insight is mediated by the researcher’s own assumptions and conceptions (Smith et al., 2009).

IPA is an idiographic approach which seeks to ‘explore the participant’s view of the world and adopt as far as possible an insider’s perspective’ (Smith, 2004). IPA acknowledges the researcher’s engagement with the participant’s account and takes an epistemological stance whereby the participants meaning to their experiences is interpreted by the researcher (Smith et al., 2009).
The current research aimed to understand how interpreters make sense of their experience of working in a mental health context. Therefore a method which seeks to explicitly examine this process of interpretation is in accordance with this aim. This approach typically uses small samples in order to ensure a thorough, systematic in-depth analysis. Such analysis would not be possible with larger samples but does allow an idiographic approach illuminating the richness of individuals experiences (Willig, 2008).

Reflexivity

The current study was conducted within the epistemological framework of critical realism within social constructionism (see Appendix J for more information). The researcher had limited clinical experience but some training related to working with interpreters. The researcher was a trainee clinical psychologist undertaking the research as part of his course requirements. There were a number of factors which interested the researcher to carry out the present study. This included prior training on how to work with interpreters, recognition of the anxiety inexperienced therapists may experience when working with an interpreter. The researcher also had an interest in social justice and equality in mental health services, both for multi-disciplinary staff and clients. The researcher acknowledged that his own past experiences and interests could shape his assumptions regarding the analysis and conclusions within the study. Inappropriate bias was avoided by the acknowledgement of Dasein, roughly translated as ‘being there’. For Heigegger, Dasein implies and necessitates reflective awareness (Smith et al., 2009). The researcher made use of regular academic supervision to discuss code and theme development. In addition, the researcher attended two IPA discussion groups, one of which included in-depth discussion of the analytic process of the research.

Method

Ethics

The current research was conducted in line with the University of Leicester and
British Psychological Society’s ethical principles (BPS, 2011). Ethical approval was granted by the University of Leicester peer reviewed ethics committee. In addition, NHS approval was received from two separate NHS Trust Research and Development Departments (see Appendices K, L, M and N for more information).

Participants

IPA demands the selection of an homogenous sample in order to ensure participants are able to give in depth accounts of a particular phenomenon (Smith et al., 2009). For the current study, the thread of homogeneity was based on the interpreters shared experience of interpreting in a mental health context for Polish individuals.

Recruitment

A purposive sample to recruit individuals was utilised. Participants were recruited through interpreting services within one regional area of the NHS. In total, 20 Polish interpreters working within the Interpreting Services were contacted via emails from their service managers. All participants were working for the NHS on a zero hour employment contract and did not take part in the study during their working hours. Participants were offered a £15 voucher as a thank you for taking part in the study.

Inclusion / Exclusion Criteria

Inclusion – (i) To have worked in a paid role as an interpreter for Polish individuals in a mental health context (either in psychotherapy, psychological assessment, or with another mental health professional). (ii) To have worked with at least one Polish individual for at least two appointments in mental health settings.

Exclusion – (i) Interpreted for Polish individuals in healthcare settings but not related to mental health. (ii) Interpreted for less than two sessions with one
individual. (iii) Only provided interpretation on a casual basis (i.e. a family member or bilingual worker whose main role is not to interpret).

All those who contacted the researcher during the recruitment stage of the project met the inclusion criteria and were included in the study.

Sample Size

Of the six participants, four were female and two male. Ages ranged from 25-62. Length of time working as an interpreter in the NHS ranged from 6 months to 10 years. Mental health formed only part of interpreters paid employment within the NHS, with many having more experience interpreting in physical health contexts. Two of the interpreters were second-generation Polish; one was first generation Polish who had been living in England for almost 50 years and three were ‘new-wave’ migrants following the EU expansion in 2004. The researcher acknowledges challenges to homogeneity in relation to the participants’ length of work experience and demographic background. The one aspect linking the participants together was their experiences of being in the room and interpreting for mental health professionals.

Table 1: Overview of participant’s experience working as an interpreter in the NHS.

<table>
<thead>
<tr>
<th>Transcript number</th>
<th>Transcript Initials</th>
<th>Pseudonym</th>
<th>Experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>1a</td>
<td>NK</td>
<td>Natalia</td>
<td>2 years</td>
</tr>
<tr>
<td>1b</td>
<td>NK</td>
<td>Natalia</td>
<td>2 years</td>
</tr>
<tr>
<td>2</td>
<td>MD</td>
<td>Marta</td>
<td>6 months</td>
</tr>
<tr>
<td>3</td>
<td>ZK</td>
<td>Zofia</td>
<td>Over 4 years</td>
</tr>
<tr>
<td>4</td>
<td>LV</td>
<td>Lena</td>
<td>9-10 years</td>
</tr>
<tr>
<td>5</td>
<td>PH</td>
<td>Pawel</td>
<td>6 years</td>
</tr>
<tr>
<td>6</td>
<td>KT</td>
<td>Kristoff</td>
<td>10 years</td>
</tr>
</tbody>
</table>

Materials

A semi-structured schedule, using a topic guide approach, was devised for the purpose of the current study (see Appendix O). The topic guide was developed
by reviewing the literature related to interpreting in a mental health context and through discussions with the academic and field supervisors involved in the study, both of whom have experience of working with interpreters. IPA allows for a flexible interview approach centered on the interviewee's account. Therefore, the topic guide was chosen as it did not require to be rigidly adhered to but instead was used to help prompt the participant as required. This method allowed the participant and researcher to engage in a dialogue so both had the opportunity to participate in the research process with an aim to produce meaning-making and interpretation.

All interviews were carried out by the researcher. Each interview was conducted in English. Interviews lasted from 40-90 minutes. One participant was interviewed over two sessions (Natalia). Mean time for each participant interview was approximately 58 minutes. Audio-recording equipment was used to record the interviews which were transcribed by the researcher.

Interviews were held in a variety of meetings rooms at the convenience of the participant, this included rooms located in NHS and university settings. One interview was held in the interpreter's own home.

**Procedure**

Individuals identified as meeting the inclusion criteria, were approached by the researcher via the NHS interpreting service they worked for. Through arrangement with the interpreting service managers, details of the study were emailed to participants outlining the research's aims and objectives. Participants were provided with the Participant Information Sheet (see Appendix P) and a consent form (see Appendix Q). Participants wishing to be involved then contacted the researcher who discussed the study and clarified any questions participants had.

Semi-structured interviews were conducted on a one-to-one basis by the researcher at a mutually convenient time and place. Lone worker policies of the Leicestershire Partnership Trust were followed by the primary researcher at all
times. Written consent for the interview to be audio recorded was sought immediately before the interview taking place.

The interview topic guide was used to explore issues related to the research questions with the researcher allowing additional questions during the course of the interview as and when deemed appropriate. Participants were given a voucher as a thank you for their participation (see Appendix R for a copy of the voucher receipt)

**Analysis of Results**

Interviews were transcribed and analysed using an IPA approach as described by Smith et al. (2009). The transcripts were coded to ensure anonymity and confidentiality. The transcription allowed for the researcher to ‘immerse’ himself in the data which subsequently enhanced the quality and coherence of the data analysis.

The IPA approach involves initially becoming familiar with the data; beginning to explore and code themes according to descriptive, linguistic and conceptual focus on a line by line basis. Emergent themes were clustered and then a master list of themes was drawn up for each individual interview. Once completed, themes across interviews were analysed to distinguish convergent and divergent patterns in the data. A process of ordering and refining of the themes took place throughout the analysis. This involved developing sub-themes and higher order categories known as super-ordinate themes. For more details on the coding and theme formation please see Appendix S.

To ensure quality of data analysis, data and interpretations were discussed with field and academic supervisors. The researcher attended and participated in The East Midlands regional IPA group on a number of occasions throughout the analysis and write-up stages. The researcher was also part of a peer support group with other novice IPA researchers to share, critique and collaborate on the analysis process. Throughout the process the researcher engaged in constant reflection and re-examination of the data.
Methods to Enhance Quality

Yardley (2000) presents four broad principles for assessing the quality of qualitative research.

1. Sensitivity to context. This was established by being sensitive to the socio-cultural milieu in which the study was situated, the existing literature and the data collection and analysis process. The researcher took a critical realist position in his analysis and was mindful of wider contextual issues during the research, notably the negative publicity around zero-hour contracts and the risk of employee exploitation, the political discourse around immigrants in the UK and the pressures on the NHS. A literature review was also conducted looking at previous research relating to the experiences of interpreters working in mental health settings. During each interview, the researcher made efforts to ‘come along side’ the participants. The researcher openly acknowledged that he was from Ireland and had migrated to the United Kingdom for economic reasons. The researcher was curious, taking a non-judgmental and not knowing stance to each interview. In addition, the researcher explained that the research was part of a doctorate in clinical psychology and therefore attempted to separate it from their NHS employers in order to give space for each participant to discuss pertinent aspects of their experience.

2. Commitment and rigour: This was demonstrated by extensive reading of the literature and attending groups on the methodology used. Care was also taken to be attentive to participants in the data collection phase discussed above. Supervision with two clinical psychologists facilitated reflection on the analysis. Supervision was used to discuss the theme development in order to clarify the researchers own thinking and to check that the theme development was logical and valid given the data collected. Each interview was transcribed by the researcher and a process of analysis was conducted for each individual participant over a period of six months. This highlighted the researcher’s personal commitment and investment to ensuring close attention to all aspects of the analysis process.
3. Transparency and coherence. Each stage of the research process has been clearly laid out in this report. A reflexive diary was kept throughout the research process by the researcher. A section specifically for the researcher’s reflections on the whole process has been written up to accompany this study. Attention was paid to careful writing and considerable drafting and re-drafting throughout the report.

4. Impact and importance. The research question follows on from recent meta-reviews on the literature on interpreters in mental health, and chose to focus on an area with little research, namely that of interpreters of Polish service users with limited English ability seeking mental health support. The plan is for the research to be disseminated though publication in a peer reviewed journal. The researcher also intends to present the finished study to interpreting and mental health services on request.

Results

From the IPA analysis of the interview transcripts, three themes were identified and developed. In describing the themes, an overarching area, which aims to link the analysis, is the super-ordinate theme of ‘being paid to be a machine for a human role’. This points to interpreters being actively engaged in a relationship with both the client and clinician when conducting their role, but not having appropriate financial recognition for the complexity of their role. This addresses a number of aspects of their work and the power structures framing their work. On the one level, when working with clinicians and clients, the participants recognise the importance of relationships and trust within this therapeutic triad.

“because I know this person I can, this particular person trust, and this person wants to open in front of me and we build a kind of relationship and the health professional also is happy to book again the interpreter, because he know how much he benefits from the service”

Natalia (Transcript 1a, 441-443)
But on the other hand, there is acknowledgement that this work is not witnessed outside of the room by their employers

“It is not great financially, working as an interpreter, because it is quite hard, we don’t get, as you say, you know, we are on zero hour contracts, so we don’t know from day one to day two what kind of work we will have.”

Zofia (Transcript 3, 728-730)

In total, three subthemes are further used to make up each of the three themes to structure the results section as shown in Table 2 below. During the interview the researcher was aware of a number of roles he could be positioned in by the participants. He was an NHS employee, trainee clinical psychologist, an Irish individual living in the United Kingdom. The researcher was open in acknowledging that he had emigrated from the island of Ireland and was working in the NHS. It was hoped that this would facilitate participants to freely express views which may have been critical of the researchers’ professional background or wider NHS culture.

Table 2: Overview of themes and subthemes

<table>
<thead>
<tr>
<th>Theme Number</th>
<th>Theme</th>
<th>Subtheme(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Just a linguist?</td>
<td>Journey into the profession;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Understanding the meaning of linguistic context;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>‘Orally bring clinician and patient together’ in a relationship.</td>
</tr>
<tr>
<td>2</td>
<td>Unspoken alliances</td>
<td>Working for the mental health worker;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The uncertainty for interpreting for mental health clients;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Working within the guidelines.</td>
</tr>
<tr>
<td>3</td>
<td>Communicating emotional</td>
<td>Emotional work;</td>
</tr>
<tr>
<td></td>
<td>reactions</td>
<td>Being professional;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Being (de)valued.</td>
</tr>
</tbody>
</table>
The themes described in Table 2 overlap with one another and are not seen as distinct separate categories. Within the super-ordinate and subthemes a number of tensions and conflicts are discussed which highlight the personal nature of the interpreters’ experiences.

The aim of the analysis was to enable a fair reflection on each participant’s experience. However, due to the large data set, it was felt by the researcher that having an emphasis on shared commonalities across participant accounts was advantageous due to word count limitations. This is opposed to providing a case study type analysis for each individual participant, commonly used with smaller samples (Smith et al., 2009). This approach of shared commonalities, whilst maintaining an idiographic focus on experiences is in line with previous IPA research (Smith et al., 2009).

In the interest of transparency, it should be noted that not all themes and subthemes are representative of all participants experiences - conflicting accounts will be discussed in the results section where appropriate. The differences in individual experiences are retained, and are discussed within themes, for example, how Kristoff and Pavel cope with traumatic content of the work in subtheme number two of the second theme. Kristoff uses strategies to distance himself, whilst Pawel does not, and notes that he may himself need therapy, as he is less defended against exposed feelings of shock and horror.

Tables were used to organise the analysis of each interview. In turn each table was used to elicit the themes from across the group. Key emergent themes for the whole group were developed to form the themes listed in this section. Group level themes were then illustrated with particular examples from individual interviews. The super-ordinate theme was considered valid as it was present in the majority of interviews. All names of participants have been changed to protect their anonymity. Table 3 shows the use of symbols within some of the quotations below.
Table 3: Use of notation in participant quotations

<table>
<thead>
<tr>
<th>Symbol</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>.....</td>
<td>Indicates a pause in the speech</td>
</tr>
<tr>
<td>[ ]</td>
<td>Indicates some words have been omitted from the quotation in order to enhance clarity for the reader</td>
</tr>
<tr>
<td>(‘non italic writing’)</td>
<td>Indicates words entered by the researcher to clarify either feelings or context of quotation.</td>
</tr>
</tbody>
</table>

Theme 1: Just a linguist?

An interpreter’s primary role is to provide an oral translation between speakers of different languages. The accounts of the participants showed that there were tensions and conflicts within themselves and between each other as to the extent their role involved other factors. The accounts ranged from interpreting in mental health being solely a linguistic role to interpreting being a series of suggestions of what is being said, with the interpreter involved in a three way process. Each individual interpreter expressed various levels of contradiction when providing descriptions of their role. There was a sense that during the interviews some participants felt safe in putting across their experiences as solely a linguistic exercise. However, during the interviews when their experiences were discussed in-depth and they began to relax, the complexity of the role, specific to mental health settings emerged. The participants discussed how interpreting in mental health involved more than Westermeyer’s (1990) ‘black-box’ (robotic) model.

Kristoff described himself as being “like a parrot”, for him this was his primary function. Throughout the interview, Kristoff maintained this stance, despite describing reactions to witnessing emotions from clients and the importance of continuity:
“I try to calm the patient down for a start. They normally open up, but that’s when the tears arrive. [ ] Well I give the lady a tissue, that’s a start”

Kristoff (Transcript 6, 246-247)

There are a number of ways to interpret Kristoff’s action of giving the lady a tissue. A psychodynamic interpretation may point to Kristoff’s reaction as possibly being a defence against a difficult or overwhelming emotion which he feels when witnessing distress in others. The act of Kristoff giving the lady a tissue may be his way to stop the lady from crying and in turn reduce his own discomfort. The tissue could be a signal that he wants her to mop up her tears and collect herself. An alternative interpretation may be that Kristoff can empathise with the lady and is limited in what he can do to help. He is unable to make physical contact with the lady to comfort her, or even give verbal containment, due to his perceived role of being the ‘parrot’ in the room, feeling unable to give verbal containment. The parroting role, which equates to Westermeyers’ (1990) ‘black box’ model means, for Kristoff, that he can only repeat the client and psychologists’ spoken word and not add comments from himself which may offer emotional containment. Therefore, one interpretation is that he resorts to what may be considered the socially acceptable action of giving the lady a tissue as his way of showing the lady that he sees her pain. Another interpretation would be that the offer of a tissue is a sign of the interpreter’s discomfort at being exposed to her pain and that he cannot offer containment so he is signalling to her to dry her tears and stop revealing her distress. It is not possible to be sure whether either of these interpretations apply in this case.

There were numerous examples of similar tensions in each transcript. Kristoff, however, was the strongest at maintaining his ‘linguist only’ position. Pawel described the role as having conversations with both the mental health worker and the patient. He took a more complex view of mental health interpreting from the beginning of the interview.
“And then it becomes a little bit more, not really, pure interpretation, more of a conversation, with me having to...suggest that the way this is being said, whether it makes any sense or not, in the context it has been said, is not what you might think, it’s something else”

Pawel (Transcript 5, 146-148)

Within this quote, Pawel communicates the complexity and his level of tolerance of uncertainty of meaning when interpreting, particularly in psychological therapy. Pawel describes it as not a ‘pure interpretation’ highlighting how his own perceptions and understanding can influence the information he receives from the patient. In addition, he recognises the context of the environments both inside and outside the session which affect the conversation. He also recognises that he is not fully aware of the effect on meaning this context has. For Pawel, he is more openly involved and active in the process, providing tentative suggestions of meaning in relation to the words spoken by the patient.

“so then it becomes a three way thing. And then it is difficult to know how long to continue along those lines and when to say nothing”

Pawel (Transcript 5, 149-150)

Subtheme 1: Journey into the profession

The interpreters give a number of reasons for entering the profession, Natalia and Zofia were students of modern languages who had an interest in language from a young age, Marta and Pawel were late comers into the profession who were happy to work part time in a flexible manner, Lena and Kristoff both chose the profession for economic reasons. However, these original reasons and motivations develop, as described by Natalia:

“I think that’s my strong point (studying languages), like, I like learning languages [] So it was like, for me a reward (being asked to come back by a client), so I felt like ‘that’s good (smile) this is what I want to achieve, not just about the money, though money is
important, that’s another, but something stimulates you for your work, your motivation for work.”

Natalia (Transcript 1a, 8-9 and 522-524)

Zofia had a similar background and reasons for becoming an interpreter as Natalia. Lena described the role fitting into her skill set as a motivating factor in becoming an interpreter “it would give me the extra experience. I can utilise my skills” (14-15). Pawel and Kristoff felt it was a good opportunity to keep themselves in active employment whilst Marta described being able to

“help people, so I thought I have inherent skills in things I have been doing forever. [ ] I (want to) keep up my Polish”.

Marta(Transcript 2, 14-15)

Subtheme 2: Understanding the meaning of linguistic context

All of the participants went to great lengths to show their primary role was to grasp the meaning of what they were hearing from the patient. In order to do this they felt that understanding the patient and their experiences aided this process. Natalia summed this up by saying:

“To grasp meaning of the sentence, because sometimes you can understand the person just if you really experience that mmm, living in that specific area and you know really what they mean, the words, the meaning of the sentence”

Natalia (Transcript 1a, 302-304)

Marta further illustrates the point by highlighting how translating the language itself does not provide an accurate interpretation of the client’s words:

“Well, you have to make sure that you are translating properly because an innuendo in English can be quite different, or a word or an emphasis, can be quite different”

Marta (Transcript 2, 286-287)
Here Natalia and Marta, suggests knowing where the patient has come from can help in understanding their experiences, this may be related both to cultural references as well as linguistic aspects such as slang words or local sayings. Pawel acknowledged how his experience as an interpreter in the NHS has improved his interpreting skills, and recognition of grasping the meaning.

“it’s given me a wider, you know, depth and breadth of, you know, trying to get the communication right, I just feel it’s so important to get it right.”

Pawel (Transcript 5, 757-759)

The majority of interpreters were able to reflect in detail of the importance of context of the words spoken and in turn translated. This acknowledgement leads to more accurate meaning making of the words spoken by the client.

**Subtheme 3: ‘Orally bring clinician and patient together’ in a relationship**

Within the interviews, there was a consensus that interpreting in mental health environments was different compared to physical health. Understanding different services, professional and individual ways of working was complex.

Marta, for example, saw her role as “literally just to, orally, in language bring them together, but not their relationship” (Transcript 2, 478-479). She described a difference in bringing people together in a relationship and bringing them together linguistically. This could be perceived as Marta wishing to distance herself from the therapeutic process and taking solely a mechanical role in the proceedings. This view of the therapeutic team was not shared by all interpreters

There was recognition of the relationships within sessions by most participants. For example, Zofia discussed her relationship with clients as being important to foster communication. These relationships need time to develop over ‘each session’ to facilitate familiarity and trust for the client and clinician. Therapy
sessions based on talking and communication rely on such relationships in order to facilitate change within the client.

“I think it makes the, it makes the assignment much comfortable and I think …mmm, you sort of, I think you have a much better rapport which I think really is much better outcome for all the three parties involved, because you do sense, when you, when you start doing the assignment.”

Lena (Transcript 4, 593-595)

However, the interpreters spoke of relationships with clients also needing firm boundaries inside and outside the sessions as Lena points out.

“And as much as you want to converse with them I think there is a danger of not to become too familiar. So I might have a conversation about very generic things…but …. I have to say sometimes they will say, ‘oh we had this and that and that’ and our daughter, ‘we had a recent bad experience’"

Lena (Transcript 4, 367-369)

In these quotations Zofia and Lena, acknowledge before sessions when they are waiting along with the client in the waiting room prior to an appointment, how clients can see her as being more than an interpreter. In these situations, they do not wish to ignore the patient as this would harm the relationship. There is a preference to speak about unrelated, ‘safe’ topics. This is not always successful as the patient has built up a picture of the interpreter as being part of the ‘therapeutic team’ and thus begins to disclose.

The system in which the interpreter finds themselves in prior to appointments, I feel is one which disempowers their profession. From Zofia and Lenas’ accounts I sensed that they found sitting with the client prior to the appointments to be awkward. Interpreters are asked to manage this with little support from the systems they work in. This dynamic can put the relationship between the interpreter and client at risk if the client sees the interpreter’s
reaction as cold. Alternatively, it puts the interpreter and mental health professional’s relationship at risk if the interpreter is seen as discussing clinically relevant details with the client prior to appointments.

**Theme 2: Unspoken alliances**

Mental health settings and particular psychotherapy rely on positive relationship formation (Martin et al., 2000). This can facilitate the therapeutic alliance and aid the client to achieve their goals for therapy. Research has shown the common indicator in determining successful outcomes in therapy is the relationship between mental health worker and client (Martin et al., 2000). The participants highlighted the importance of understanding, connecting and building trust with the clients. Natalia saying:

> “I have to understand these people, it may take so long, they are quite down with, you know, the way they feel, so supporting them, giving them my support, personal support [] We give each other the trust, I think it’s the best, main thing, when you work as interpreter”

Natalia (Transcript 1a, 571-572 and 47)

In these quotes Natalia recognises trust is a two way process between her and the client. She feels trust is an important part of her role and facilitates communication. At the same time she highlights the psychological distancing between herself and clients in the phrase, “these people”. Distancing herself from clients may be Natalia’s way of identifying more closely and to be seen on par with the mental health professionals. This may be also understood as an attempt to distance herself from the pain and suffering often expressed in mental health settings.

Lena expressed similar assertions regarding ‘connection’ from the point of view of the client

> “they see you more as a …not just as an interpreter but someone you can share, or have that emotional support somehow.”
This can further complicate the notion of having uncomplicated boundaries between the interpreter and client, pointing to the view that interpreters are more involved when compared to being ‘black boxes’. However, this is not recognised by the structures within which interpreters work.

Subtheme 1: Working for the mental health worker

All interpreters recognised that within sessions the mental health clinician has clinical responsibility for the sessions. They took the lead from the clinician and aimed to work within their boundaries. This theme relates to the relationship between the interpreter and the mental health worker. It also highlights the power dynamic within sessions, as Pawel points out:

“So I always take the lead of the health professional, I always say, do you want me to say more about that....and then, it’s awkward because depending on the state of the patient...”

Pawel (Transcript 5, 154-155)

In this quotation, Pawel acknowledged the struggles of being the primary communication point for the client, but not being fully aware of the clinician’s goal(s) in the appointment. This is an ongoing tension for Pawel, which he finds uncomfortable. Such tensions highlight the need for briefing and debriefing and open communication between interpreters and mental health workers. Marta also described negative feelings following mental health sessions:

“I think like I’m being a bit of a nuisance with the paperwork and they are busy people to say well can you fill this in, but well they have to, so I, I’ve not had anybody say they are not going to fill in this assessment form, go away”

Marta (Transcript 2, 374-376)
Marta expressed her fears of “being a nuisance” for the mental health worker, locating her nuisance after the appointment has ended when she is required to have her paperwork signed. Perhaps Marta sees the difference in language, the extra time needed for appointments and her necessary input as being a strain on the mental health workers time which she locates in this particular requirement. However, she recognises this is not backed up by any evidence from mental health workers and perhaps is part of her own ‘getting used to’ her role.

Subtheme 2: The uncertainty for interpreting for mental health clients

The participants all spoke of interpreting in mental health as being different compared to physical health settings within the NHS. Pawel described it as ‘quite intense’ because he is unsure how the client may react. He speaks of feeling “confused” at times and needing to “concentrate” throughout the session. He goes on to say:

“I found that mmm...daunting, when I heard the types of things that mmm, I may have to contribute to but also challenging, interesting, you know”

Pawel (Transcript 5, 50-51)

In this quotation Pawel, displays the challenges of mental health interpreting, his anxieties of the unknown in relation to the client and the appointment itself. At the same time he seems to see this positively as challenging his interpreting skills.

Kristoff described mental health interpreting as ‘linguistically easier’ than physical health due to not having to use medical jargon and sentences being easier to translate. At the same time he recognises the difficulty for clinicians working in mental health and his experiences of clients attempting to act more unwell for financial gain.
“because how do you measure the mentality state of the patient...you can only observe and listen to what they are saying...because I've had situation, where you can clearly see where this act is put on...you know what I mean?”

Kristoff (Transcript 6, 274-276)

In this quotation, Kristoff highlights the difficulty faced by mental health professionals with the lack of objectivity in the mental health environment he interprets in. He expresses doubt in the stories of clients, perhaps as a way of emotionally distancing himself from accounts, or from seeing clients in other settings at other times who present differently. The accounts which Kristoff bears witness to within mental health settings can be emotionally unsettling. A psychodynamic interpretation of Kristoff casting doubt on client stories may be that he is in denial of others’ painful realities. This defence allows Kristoff to continue his interpreting role without being overwhelmed by accounts interpreted for.

Pawel described feeling shocked at the accounts given in mental health settings during his role. At times he feels left out, believing that the mental health worker and the client have more knowledge than him regarding the background of the patient, which he can find difficult:

“In other instances, I felt very shocked as to what’s been suddenly revealed. Which obviously the patient knows about and the therapist knows about but it’s new to me. And mmm.....you know, it’s almost as though, in some instances, if it’s shocking information, it’s possibly that you need therapy yourself [laughs] afterwards, you know. Some form of release...mmm..”

Pawel (Transcript 5, 289-293)

In this quotation Pawel begins to open up to the emotional difficulty of interpreting in mental health settings. He described interpreting for patients who have been abused, threatened with extreme violence, suffering bereavement. He acknowledges the lack of support given to interpreters, by expressing a
possible need for therapy or some form of release. In addition, Pawel presents here an example of how one member of the triadic relationship can feel left out. In this case, Pawel feels the other two members have more knowledge than himself.

As a researcher, I felt a strong sense of uncertainty when interpreters work in mental health settings. They can be shocked at hearing clients’ accounts and react to this shock by distancing themselves from what they hear. This may be in order to manage their own anxiety and emotions in order to complete their assignments.

Following on from Pawel’s expression of mental health work being emotionally challenging, Zofia discussed the anxiety of meeting new patients. She chooses to focus on the first appointment and the uncertainty of what to expect when expressing this anxiety.

“The first appointment is generally the most difficult, especially if there is more difficult problems, they would like to talk about because I can tell they feel, if they are not sure if they can mention that or how, how they feel a little bit ashamed maybe, or shy”

Zofia (Transcript 3, 420-423)

She recognises the difficulty for clients, feelings of shame, uncertainty and anxiety. However, she later acknowledges how familiarity overcomes these initial issues; “but that usually resolves itself, the longer you go, the easier it is, the relationship.” (423). Lena spoke of similar issues in her role. She described the changes she has seen in herself as a result of gaining more experience.

“You are more experienced as an interpreter, you handle it much better because you’ve got the better understanding of yourself and how you react in circumstances, so you learn from previous experience”.

Lena (Transcript 4, 134-136)
She places an importance on experience and how this influences her knowledge and confidence to deal with new situations which arise in her role. Mental health is highly stigmatized in society; the dominant discourse describing individuals with mental health problems are often fostering negative stereotypes. Despite evidence suggesting individuals with serious mental health problems are more likely to be the victims of crime than the perpetrators. This anxiety can manifest itself within session, once an understanding is built, it can shift unto the difficult emotional narratives often discussed within therapy. For the interpreter this can be emotional, anxiety provoking and intense.

**Subtheme 3: Working within the guidelines**

This subtheme relates to interpreters alluding to the importance of their professional identity and following the guidelines set out for them. These guidelines include the NRPSI guidelines and in house codes of conduct. This was notable throughout each interview. For example, Zofia describes her role as ‘pure communication’. This differs from Pawel’s earlier statement that interpreting in mental health is not a pure interpretation and highlights the mixed messages in relation to mental health interpreting.

“So I, I purely should be there to process the languages both for the health professional and patient can communicate with each other, so pure communication I would say.”

Zofia (Transcript 3, 65-66)

Later we see Pawel stating that his training tells him not to express opinions and just to say the words. Though he alludes to the context which the words are spoken by the client:

“.....you know, we’re trained to, you know, not express opinions and we are trained to, you know, just say the words, try to make them as in context as possible and then to walk away.”

Pawel (Transcript 5, 759-760)
He also speaks of the need to ‘walk away’ alluding to his training emphasising not to get emotionally involved with the work. This may be one major reason why the interpreters have been hesitant in discussing the emotional impact of their work at the outset. It would suggest that having emotional reactions, for them, can equate to not doing the job properly.

**Theme 3: Communicating emotions**

Most interpreters spoke of times when working in mental health settings caused them to become emotional during and/or after sessions. Emotions were usually linked to feeling unprepared and shocked at what had suddenly been disclosed or resonating with clients narratives. Expressing emotions was linked with a sense of shame in some interpreters.

Throughout all of the interviews, there seemed to be an ongoing tension with the interpreters as to how they emotionally experience mental health sessions. There was a sense that they wished for having no emotional reaction. Pawel summed this up by saying:

“It doesn’t affect me, I don’t think it affects me. And just move on and look for a more positive outcome with the next mental health...interpretation [ ] During or after... I have had, some after thoughts that were black, negative, but mostly ‘oh dear’ but mostly it’s the job and you... then wait for the next one.”

Pawel (Transcript 5, 369-370 and 400-401)

He initially attempts to suggest that the interpreting does not affect him, but immediately there is a doubt in his mind. He reacts to emotional sessions by normalising it as being part of his job and looking for positive outcomes. Later in the interview he expresses rumination after some sessions ‘black, negative thoughts’. When recognising that the role does, at times, affect him he chooses to psychologically distance himself from traumatic stories from clients by comparing these stories to those he watches on TV.
“Interpreting for them, you know, I can withdraw and I can...reach out... so I can do that as it goes along... and mm... just to sort of coax it along really, or just to not get in that way... so when you are looking at it that way... it’s just somebody’s story, which to be honest... you could... you know, watch something like Nordic Noir, you could watch The Killing or something like that”

Pawel (Transcript 5, 384-386)

This distancing himself from the stories he interprets for is Pawel’s coping style to avoid becoming emotional within the session. He does this so he can maintain a level of composure within the session to perform his role without getting emotionally involved at the time. This example highlights how some interpreters can use avoidance of emotions and detachment to fulfil duties in the short term.

Subtheme 1: Emotional work

Zofia also spoke of the emotional impact of interpreting:

“Well I mmm I quite often get emotional, especially when I’ve got appointments where there is a child involved and if there is an abuse, or if there is mmm, an illness, like a severe illness. I, I, I, it takes me sometime to deal with this and I can’t leave it, I can’t let it go”

Zofia (Transcript 3, 201-203)

At times she feels trapped with the stories she hears “I can’t let it go”, with little professional support and time with the mental health worker she is reliant on herself to cope with such emotions. This was similarly expressed by Lena:

“I feel like sometimes, you want to give her a hug, but I think that session was really emotional for me, because when I go back home and the way she reacted everything, I sort of like have her in front of my face”

Lena (Transcript 4, 155-157)
Lena highlights tensions in herself when interpreting, from being professional and being human.

“as a human being, you want to, you want to say something. However, you, it’s not your job to do so.”

Lena (Transcript 4, 121-122)

Kristoff was the only interpreter who spoke of having no emotional reaction regarding his role, aligning himself to the clinician.

“Well it doesn’t bother me really, you know, I just sit there and wait for the moment is over, passes by the emotions. And so does the professional, you know, we don’t kind of interfere during that moment, of emotions, let the patient settle down a bit...”

Kristoff (Transcript 6, 266-268)

Subtheme 2: Being professional

Mental health professionals would receive a referral and have a basic understanding of why the individual has been referred. Interpreters, in comparison spoke of having little preparation. They are being asked to put themselves into these distressing situations and not to be affected. This is difficult considering the emotive atmosphere prevalent in mental health settings.

This may highlight a level of discrimination towards interpreters, who by and large are left to dealing with emotions themselves. Whilst at the same time being under pressure to create a good impression with the clinician. The clinician is in a position of power over whether the interpreter returns to the follow up appointment as they complete an assessment form on the interpreter’s performance. All of the interpreters, apart from Pawel, spoke of limited opportunity for pre or debriefs.

With most participants expressing emotional reactions to their role, there was quite a bit of reflection on how this ‘should’ be managed, as Zofia points out:
“Then you as an interpreter can be slightly shocked and you are only a human being, so you have to, try to...pull yourself together, to act as an interpreter, and not to show your emotions...and not to show your...reactions”

Zofia (Transcript 3, 133-135)

Zofia focuses on ‘being professional’ at these moments to hide her real feelings.

“Because I think, I guess if she sees me crying (client) and I see her crying, it’s kind of, natural that you start sympathising with the other person who cries, and they, they become even more emotional, so I, I didn’t feel very comfortable afterwards because I thought I didn’t look very professional, but I couldn’t stop myself, if I knew in advance, this was the case...[ ] I probably could have prepared myself...”

Zofia (Transcript 3, 152-155 and 160-161)

She experienced a sense of shame at her reaction to the client’s account. She describes a sense of unfairness in the process that she was not informed beforehand of the reasons the client had come into the appointment. These reasons have resonance with Zofia and drew emotions from her.

All of the interpreters shared a sense of satisfaction when therapy sessions have a positive outcome. They note the shared experience with the mental health worker and can acknowledge how their skills were useful in helping the individual. Lena stated:

“And after six or so sessions and even with the professional you can share the experience, you know is nice to see the progress with the client, so it somehow gives you that rewarding satisfaction as an interpreter, yes my skills were useful somehow, you know, you have moved them from A to B... mmm so, yeah......”

Lena (Transcript 4, 408-411)
Subtheme 3: being (de)valued.

The final subtheme relates to the support and emotional reactions to feeling valued and devalued whilst doing their jobs. There was a sense that the interpreters felt generally valued by mental health professionals, despite isolated cases of lack of respect. However, in relation to the wider system, the interpreters could be devalued in the sense that their roles are not adequately remunerated and there is little in the way of training at the beginning of their careers or, emotional support during difficult assignments.

Natalia describes feeling uncomfortable and under pressure to provide an answer for the patient.

“The health professional is watching you and is like (‘stare’) and I don’t know what to do, and I’m just repeating the question and ‘I’m sorry what is this and that’, yes?”

Natalia (Transcript 1a, 720-721)

Lena disclosed similar experiences to Natalia, stating:

“Sometimes, they might see the interpreter as the one who might know the answer before the clients answer the question”.

“It’s not for me to interpret someone else’s statements so, I don’t, I don’t feel like it was positive experience, I felt like I was blamed for not getting the right answer to his questions”

Lena (Transcript 4, 259-261 and 509-511)

In relation to the job, all of the interpreters were employed under zero hour contracts and felt that their pay was not a true representation of their value:

“I mean financially we are not valued because we are not earning enough but I know that mental health professionals value that we are
being there and also the patients [ ] I could be earning the same, probably doing a simple job, on the checkouts somewhere.”
Zofia (Transcript 3, 765-767 and 741)

Lena described a situation just after an emotive session with a client. She described the mental health professional’s response as being negative:

“I just said, just sort of proactively said I felt it was quite emotional for me, and she said ‘well, I have to deal with that everyday’ and after that comment I thought.... ‘yes, ok, obviously that is part of your job, but mmm…’ but I thought it was a bit sarcastic, so I left it.”
Lena (Transcript 4, 212-214)

“I’ve had a couple of comments like, “well, you still get paid so it doesn’t really matter to you (having a client not attending appointment)”, but I think it’s doesn’t really matter if you get paid or not, you are thinking that, you should be a bit more respectful and handle it in a more professional way.”
Lena (Transcript 4, 281-284)

On a more positive note, towards the end of the interview, Zofia, who on the surface denied any relationship within the settings of her role, described the value of continuity in sessions.

“I think they, it is to do with the fact that you come to each session and kind of build the trust in you and they feel very comfortable around you because they know they’ve got the same person who comes and helps them with their problems and without them they would struggle to progress in their wellbeing.”
Zofia (Transcript 3, 405-407)

From the interpreters’ accounts during the research, at times, they can feel unprepared for their work. This can affect them by being shocked at what’s been disclosed in session. For some, they cope with the anxiety by detaching
themselves from the realities of clients’ accounts. One example being relating client accounts to fiction. Interpreters receive little emotional support and have faced times of being disregarded by mental health professionals when seeking this support out.

Discussion

This study aimed to understand how Polish interpreters experience their roles in adult mental health settings and to understand how they interpret the triadic relationship between themselves, the client and mental health professional when interpreting. In order to access rich, contextualised accounts of their work an interpretative phenomenological approach was utilised. Listening to the participants reflect on their experiences, it became clear that interpreting for mental health professionals was considered more complex when compared to other settings. Miller et al. (2005) highlights the complex emotional reactions that may arise in the psychotherapy triad which can impact on the therapeutic alliance. The majority of participants expressed similar reactions in their roles.

The suggested findings appear to illustrate a myriad of reasons for interpreters’ reactions to the challenges in their role. These reasons include their personal journey into the profession, their level of experience, relationship and familiarity with the clinician and client, and how empowered they feel to discuss issues with the clinician. Green et al. (2012) discussed how interpreters can find mental health interpreting as being ‘too heavy to handle’. Green et al. (2012) described how interpreters can find their work to be distressing. There was a sense of “absorbing” the stories they interpret in mental health settings. During the interviews I got a sense of frustration from both Zofia and Lena due to them being put in an awkward position by systemic factors. They were often asked to wait in the waiting room with the clients prior to appointments when they felt it would be more suitable to be elsewhere.

The current study provides empirical evidence to support the understanding that interpreters play a multitude of roles, over and above that of the linguist. They are involved in a triadic relationship along with the clinician and client.
Interpreters can find aspects of their role emotionally difficult. In addition, they are less likely to speak about their difficulties and uncertainties to clinicians due to not being given the time and space and also to maintain a sense of their professional identity. This relates to them being seen as ‘just a linguist’ and following their professional guidelines (NRPSI) of not becoming emotionally involved in the session in which they interpret for. Resera et al. (2014) discussed how interpreters spoke of the importance of gaining trust, but balancing this with stopping the client from becoming emotionally attached.

Greenhalgh et al. (2006) found that interpreters occupy multiple social roles, including being a translator, interpersonal mediator, system mediator, educator, advocate and link worker.

One super-ordinate theme was created for the analysis - this was ‘being paid to be a machine for a human role’. Three broad themes were developed from the analysis. The first was titled ‘Just a linguist?’. This theme brought to account the tensions within the interpreter’s role. On the surface, they are paid on an hourly basis, normally on zero-hour contracts. They are reliant on mental health and other services to provide demand for their role. This puts the interpreter in a vulnerable position, for if they are asked not to come back, they receive no pay. Most of the participants spoke of having to ask mental health professionals to fill out an assessment form and time sheet after each session.

The second theme of ‘unspoken alliances’ covered a number of roles which are not discussed openly. With regards to the mental health worker there was acknowledgement from all interpreters that the clinician is clinically responsible for the appointments. However, the interpreters also give the clients support, built rapport and gained trust with clients and mental health professionals. At times they also shared the emotional support given to the client.

Tribe and Thompson (2009) discuss the prospect of splitting and pairing occurring in triadic relationships. Pawel gave a good example of this when he spoke of feeling like he was the only one without the full available information on the client. In addition, Marta would describe her presence as getting in the way or being a nuisance.
There was little explicit uncertainty when it came to working with new mental health professionals despite alluding to how clinicians can work differently. Perhaps the participants felt more at ease projecting their own anxieties onto clients rather than clinicians, as they were talking to a trainee clinical psychologist. Research has shown that effective communication can be hindered between healthcare employees due to their professional group membership (Soothill et al., 1995). Most of the interpreters alluded to the clinician holding power over whether they returned to a follow up appointment. It should be noted that this is not the case in much of the NHS.

The participants did not explicitly discuss their professional guidelines, or in-house codes of conduct or training but each alluded to a strict set of boundaries, between themselves and with the clients and clinicians. There were efforts to maintain this professional stance during the interviews. However, each participant spoke of having emotional reactions to the accounts they heard within appointments. Previous research has suggested that interpreters may suffer from severe emotional stress due to their roles. The participants did not discuss their emotional reactions as being unmanageable or affecting them long term. This may reflect on the types of clients they are interpreting for compared to other literature with a focus on asylum seekers and refugees.

The hesitancy in discussing difficult appointments and a feeling of shame when disclosing emotions whilst doing their role may have been related to participants wishing to preserve their professional identity and show they were working in accordance to their guidelines (NRPSI). Social identity theory (SIT) (Tajfel & Turner, 1986) and Self Categorisation theory (SCT) (Turner, 1987) may be relevant to interpreters as they experience themselves as distinguished from other professional healthcare groups.

SIT and SCT are two of many possible models which to mention as possible options regarding interpreters preserving their identity. Also known as the social identity approach (Hornsey, 2008) in development from the early 1970’s these models have been highly influential in understanding of group processes.
and intergroup relations. Key features of these approaches is that they take their understanding as a starting point for analysis. Recognising that individual or groups actions are shaped by the social and structural realities placed upon them (Haslam, 2004). SIT and SCT are not without their critiques, notably the limitations of the experimental paradigm in which they were developed. For more information on the theories please refer to Hornsey (2008) and Haslam (2004).

Clinicians receive clinical supervision in order to discuss emotional reactions to their work. Clinicians are also highly trained and well paid. The interpreters are in precarious position employment wise and have little or no support offered to them, either from the responsible clinician or their employers. They are asked not to be emotionally impacted in the work they do, which is difficult for anyone who witnesses distress in another. As a result they may be more likely to hide their feelings in order to maintain a ‘professional’ stance. This was reflected within the interviews when most of the interpreters initially stated they did not get emotionally affected in their roles but went onto give examples of when they were. Previous research has shown that interpreters who show their emotions within sessions can feel that it is “unprofessional” (Splevins et al., 2012).

The system of their work provides a structural disempowerment, asking interpreters to work in a precarious position in relation to their mental health work colleges, without always having, in their view, adequate preparation and to be assessed on their skills. This may contribute to participants feeling devalued in their work. Habermasian theory could explain this as difficulties between the system and the lifeworld. The participants acknowledge the importance of understanding, trust, relationships to help them fulfil their role. However, the system is one which keeps them as linguistic tools and does not acknowledge the additional realities of their work. The system may politicise immigration and the National Health Service for the gains of some, at the expense of others.

The participants accounts show that interpreters get their value from open lines of communication, team work, developing good relationships with mental health professionals, having confidence to ask questions when they do not
understand, and seeing the client improve. As Patel (2003) acknowledges interpreters goals are similar to that of the mental health professional. All of this may require the interpreter to almost go against their code of conduct (i.e. NRPSI, 2011, or in house service codes of conduct). As Pawel pointed out in order for him to do his job properly he has to partake in a series suggestions of what is said in order to put across an accurate account of the words he interprets. He recognises that these are his opinion given all the information he has at his disposal i.e. the words said and context in which they are said. In the view of most of the participants this leads to better, more accurate work, focussed on the meaning and on the context of their clients.

Only some of the interpreters had formal interpreting qualifications. All interpreters had in-house training relating to interpreting in health care settings. It was unclear as to the amount of formal training they had had of mental health interpreting. Whether an interpreter had formal qualifications depended on the service they were in when they joined that service. There did not seem to be a consistency across the two trusts where recruitment took place as to the need for formal interpreting qualifications. This may lead to questions regarding the standard of interpreting on offer.

**Implications of findings**

*Clinical Psychology*

Findings from this research identify some areas of improvement around enhancing the use of the BPS guidelines and consideration for psychologists when working with interpreters to give them space and opportunity to discuss their experiences, emotional reactions to the appointments or triadic relationships. Unfortunately, it would seem that these guidelines are not being followed by clinical psychologists at all opportunities. Furthermore, there have been accounts given by interpreters of being disrespected by allied health professionals in the interview data.
Given that clinical psychologists play an important role in multi-disciplinary teams and provide clinical supervision to other mental health professionals. The profession should be doing more to understand the needs and requirements of interpreters both on a local and national level. On a local level this could mean requiring clinical psychologists to take the lead in ensuring the implementation of interpreting guidelines in services. Clinical psychologists could also provide supervision for interpreters on a regular basis. On a national level clinical psychologists have the capabilities to conduct primary research into the experiences of interpreters who work in specific mental health services to understand how clients, interpreters and service cultures influence the quality of the interpreting work.

*Interpreting services*

Interpreting services may wish to consider actively reaching out to individual interpreters and provide support, normalisation and possible peer supervision to promote dialogue between interpreters in order to learn from each other’s experiences.

*Wider NHS*

The wider NHS system should be doing more to make sure good, experienced interpreters are rewarded for their knowledge and skills. Providing training at the beginning of their careers and regular updated training would be welcomed. In addition, interpreters should be recognised for their cultural competence and knowledge sharing.

The findings highlight the need for open dialogue between mental health workers and interpreters prior to, and after appointments with clients on a consistent basis. These pre-briefs and debriefs would serve to share expectations and experiences of both professionals. Having open lines of communication would aid some of the difficulties experienced by interpreters.
Such open dialogue is not a sole responsibility of individual staff. It has already been noted that interpreters are employed on zero hour contracts, with little security of a set weekly wage. Mental health workers are increasingly under pressure to do ‘more for less’. Short termism within the NHS may limit the amount of time to do the work properly. But as Pawel points out

“What’s the point of rushing and getting it all wrong.....so, so the resourcing of it, we all know it’s difficult, but it’s necessary”

Pawel (Transcript 5, 778-779)

Strengths and limitations of current study

The sample size of six participants is within the guidelines for an IPA study, and the participants were reasonably mixed in terms of their sex, age, length of experience in their role. However, due to recruitment difficulties the participants were recruited from two of interpreting services, providing the possibility that interpreters from other services could have different experiences.

The participants came from a wide range of backgrounds and had varied paths into the profession. The reasons given for being in this role were economic and using skills they have previously attained.

The rationale behind interviewing Polish interpreters who interpret in mental health settings was to access experiences of those who interpret for economic migrants. The participants were recruited via the service they work for and were interviewed by a trainee clinical psychologist about their work with mental health professionals. This may have limited the information they felt able to share. Limitations to the current study include the difficulty of ascertaining whether or not participants felt that they should provide socially desirable answers. In order to mitigate this, the participants were assured of confidentiality and anonymity.

IPA was chosen as the most appropriate methodology for the current research to meet the aims of focusing on interpreter’s experiences of their role and the
triadic relationships they find themselves in. The analysis was able to generate some strong themes to explain aspects of what it is like to work as an interpreter for mental health professionals.

The use of one analyst can be viewed both as a weakness and strength to the research. By documenting the assumptions and biases of the researcher, being open and committed to the ‘critical realist’ perspective, the study acknowledges the researcher’s influence cannot be separated from its findings (Sandelowski & Barroso, 2002). The researcher acknowledges that the findings give an account of his own interpretation of accounts given by individual participants. There, his contribution is entwined throughout the analysis (Smith et al., 2009). Inter-rater reliability was deemed as meaningless during the data collection and analysis stage of the study. Yardley (2000) states that checking of themes by another qualitative researcher would be seen as constructing an alternative form of reality, as opposed to providing validation of the first.

The findings are therefore not generalisable. They are to be considered as one person’s account of six individual accounts given in a single interview with each participant of their experiences of their role. However, the current study provides additional evidence of the multiple roles and alliances the interpreters are asked to participate in. These, from the interpreter’s point of view, are not always fully recognised by employers and mental health professionals.

Recommendations for further research

Future research looking into the content of sessions with interpreters would be beneficial. This would focus on how the triadic relationship is developed and maintained by all three parties involved. Future research into how interpreters interpret meaning and context in their role would also be fruitful. Again, by focusing on the content of real life settings, such naturalistic data would provide further evidence of the experiences interpreters face in their day to day roles.

Future research might benefit from taking a participative action research approach with interpreters taking the lead. This could provide beneficial action
based research to highlight and make changes in relation to some empowerment issues they may face.

Conclusion

The findings of the current research emphasis that it is particularly important for clinicians, mental health and interpreting services to take into account the emotional impact and disempowerment caused by structural systemic factors which limit the voice of the interpreter. This study plays an important part in deepening our understanding of the interpreting process and how interpreters perceive the triadic relationship.

The findings from this ideographic study suggest that each interpreter’s experience of their role is unique. Though there are a number of commonalities between each account. Furthermore, these findings highlight the disempowered position some interpreters face when compared to mental health professionals in emotive situations.

References


Part three: Critical Appraisal
Part three: Critical Appraisal

Overview

This section is an account of my research journey. It is based on the reflective notes, kept in my research diary and updated throughout the process. The aims within this section are to personally reflect on my experiences of designing, conducting and writing an independent piece of research; to consider limitations of the study and to summarise my learning from this research experience.

Choice of project

I completed my undergraduate degree at a University which placed an equal weight on quantitative and qualitative research methods. I found the carrying out and analysis of qualitative research to be an enjoyable and worthwhile endeavour. At the beginning of the training course I was fortunate in having the freedom to develop a research topic of my choosing. My personal and professional background has allowed me to recognise social injustices which affect the lives of individuals, communities and wider society. Therefore, I wished to produce a piece of research that was psychological in nature but also related to wider social problems faced by individuals.

I moved to England from the north of Ireland ten years ago. This was one year after the expansion of the EU. Coming from Ireland, which has its own strong narrative of emigration, I have been interested in the experiences of those moving to new countries. In my time of studying at the University of Huddersfield, I struck up many friendships with individuals from the European continent and particularly from Poland. Pollard et al. (2008) comments that Polish migrants generally represent a different type of migrant compared with other ethnic minorities who have previously come to the UK. Polish people are predominantly white and Catholic, and without a post-colonial connection.
There are a number of similarities between Polish migrants and Irish migrants, notably being of white and mainly catholic background. There are also differences such as language and the post-colonial connection to the UK.

Many years ago, I can recall being told of a conversation between a Polish friend and an Irish lady. My friend was annoyed with the ‘compliments’ from the Irish lady who repeatedly stated that she ‘loved’ Polish people because they were ‘good workers’ who were often employed on her father’s farm. My friend spoke of feeling dehumanised and of being seen as nothing more than ‘cheap labour’ in western counties. What surprised my friend and myself was the realisation that the Irish lady genuinely believed that what she was saying was complimentary and was oblivious to the hurt she had caused.

This story has stuck with me throughout my travels into the clinical psychology profession. I have developed an awareness of how well educated, good hearted individuals can unconsciously be discriminatory by not taking into account the needs and wishes of others.

During the clinical psychology training I have had teaching related to the difficulties faced by economic migrants, asylum seekers and refugees in accessing psychological therapy in the UK. During one such teaching session, a remark was made about how interpreters may feel listening to traumatic narratives, which trained Professionals can find difficult. There was also a brief discussion regarding the lack of support interpreters received and how interesting it would be to find out about their experiences.

In developing a proposal a number of avenues were looked into. A recent literature review called on further research into the relationship dynamics between healthcare professionals, interpreters and patients (Brisset et al., 2013). An idea of asking interpreters and psychologists to come together and discuss their work in focus groups was encouraged. However, due to time constraints, it was felt that such a project would be difficult to organise and complete. Instead, I decided to interview interpreters about their experiences working with mental health professionals.
I had never worked with interpreters before and felt the conduct of this research would inform my own work with individuals with limited English in the future. I approached a psychologist within a service who works with interpreters on a frequent basis and was delighted when she agreed to provide me with field supervision.

Choice of methodology and design

A review of the literature highlighted a scarcity of empirical research directly related to interpreters’ experiences. The available literature often commented on mental health professionals’ accounts, clinical observations and reflective overviews, for example Sande (1995) and Tribe (1998).

I chose to focus the research question on Polish interpreters as previous literature had a tendency to focus on the work of interpreters who worked with asylum seekers and refugees. I felt that those interpreters were more likely to work in specialist mental health services and their experiences may be different to interpreters of economic migrants. Only one study in the UK has been conducted with interpreters of one specific ethnic background (Green et al., 2012). I felt that focusing interpreters of Polish language would be of interest to stakeholders interested in this area.

Given the limited amount of previous studies which includes the interpreter’s own voice, a variety of qualitative methodologies were considered. These included grounded theory, discourse analysis and phenomenology. Starks & Trinidad (2007) provided a useful description of three qualitative interpretive approaches to help aid the chosen approach.

I felt that Interpretative Phenomenological Analysis fitted with me conceptually and I wished to develop a fuller understanding in this approach by conducting research. IPA has a focus on individual experience and phenomenology which was most appropriate to meet the aims of the research.
Conducting the research

Ethical approval

I gained ethical approval from the University of Leicester for the research to take place. Due to the fact that my participants would be recruited through the NHS, I then had to obtain approval through two separate Research and Development Departments from different NHS trusts. This process was lengthy, at the same time it was a good experience in acknowledging the considerations needed in an application for ethical approval. I found the Code of Conduct developed by the BPS on ethical principles to be great help (BPS, 2005). The process provided me with knowledge and competence for any future research I may wish to carry out. I also found a new appreciation for the commitment and work of researchers to get their studies through the early stages of the process.

Recruitment

Prior to submitting my ethics application, I had contacted and had some preliminary conversations with the managers of two interpreting services to gauge their support in facilitating the study. The two services agreed to electronically forward information of the study to their interpreters. However, both acknowledged the limited number of potential participants in their service. Another issue was related to the interpreters having unstructured and changeable working hours. Interpreters would sometimes be called to work at short notice and there were discussions on how the research should not interfere with the interpreters paid work. This was agreed, and the services then agreed to forward on information of the study when I was ready to recruit.

I was aware that other professionals are often asked to participate in research studies during their paid time at work. It was unfortunate that this would not be the case for interpreters. As an offer of my thanks to participants, I chose to offer a £15 gift voucher per interview. This figure was deemed acceptable by
the ethics committee and research and development departments for the free time given by participants to the study.

The recruitment process occurred soon after all approvals were gained. This was an anxious period as I was unsure how interested or available interpreters would be to participate in the study. As it turned out, I need not have been, as the recruitment was fairly straightforward. The email containing a brief summary of the research, participant information sheet and consent form was sent to the interpreting service managers who in turn forwarded it onto their Polish speaking interpreters. Over a period of six to eight weeks, all participants had either contacted me directly or had asked the interpreting managers to pass on their details in order for me to contact them. Six participants volunteered to take part. This number was deemed as appropriate for an IPA study (Smith & Osborn, 2003).

An IPA approach, idiographic in nature, does not prescribe a ‘right’ sample size and suggests that a number of factors should be taken into account. IPA places an emphasis on depth and quality of analysis as opposed to quantity of participants (Smith et al., 2009). The study did not discuss data saturation but instead choose to use the idea of sufficiency. Under the constraints of a DClinPsy, and having started this particular piece of research one year later than planned due to a previous study being withdrawn at the ethics stage, I deemed having appropriate time for analysis as being more important than having a greater number of interviews to analyse.

Interviews

The interviews were enjoyable to be a part of. I was humbled by the experiences and expertise which the interpreters brought to their role. Despite having conducted research interviews for an undergraduate project and a service evaluation, I considered myself a novice in conducting a research using an IPA approach. The interviews were anxiety-provoking as I felt each one was vitally important to the research process. In hindsight, I felt each interview was different, so it was difficult to determine how my research interview skills
developed throughout the study. I found the experience of ‘bracketing’ difficult during the interviews. Bracketing is the suspending of prior knowledge and pre-suppositions (Husserl, 1999).

At times I felt during the interviews, the participants looked at me as a clinician. I felt the urge in some interviews to work therapeutically with the interpreters and to normalise some of the emotions they were expressing and discussing during their interviews. Some participants were anxious to present themselves in a certain way and to offer the ‘right’ answer. This led me to think about my own role and how this influenced the answers given. I reflected on how being a trainee clinical psychologist conducting research may have influenced participants to present themselves in a certain way that would show themselves, and their profession, in a positive light.

Participants were at times hesitant to discuss negative experiences with mental health workers. One participant, after the interview asked if “I had got what I needed”. I responded by repeating that there were no right answers and all I wished was to hear about their experiences. The participant then told me about times when mental health professionals had been rude and dismissive of her. Unfortunately, there was no opportunity to include this in the main analysis. However, it did open the possibility of the need for time and trust to develop between researcher and participant for disclosing a full and wide-ranging account of their experience. Unfortunately, due to the limited capacity of the research I was not capable of achieving this.

I was conscious of my position from the first interview and used supervision to reflect on this. This led me to critique the whole study and to conclude that the interviews are accounts of how interpreters explain their experiences to a researcher who is also a mental health professional. I feel that if they were talking to an independent researcher or fellow interpreter some of the answers and experiences would be different in content. For example, there may have been more accounts of the difficulties of working with mental health professionals, being shown a lack of respect in some instances. This reinforces
the studies lack of generalisability. However, at the same time, many of the interviews contained rich data to provide sound analysis.

Transcribing

Transcribing is more than putting the words said during an interview in text form (Tilley, 2003). For this reason, I chose to do the transcribing myself as I felt this would form the initial stage of the analysis and would allow me to begin to immerse myself in the interview data. It was a slow and lengthy process. Initially I thought about transcribing immediately after each interview, but choose not to as I felt this may influence other interviews and my struggles of ‘bracketing’ each interview experience. I felt vindicated once I began transcribing and immediately was able mentally record codes and ideas which had not previously occurred during the interview process.

Analysis

This was my first attempt at conducting IPA analysis on an independent piece of research. Prior to beginning the analysis, I read a number of research studies which made use of IPA; read books on IPA (e.g. Smith et al., 2009) and information from training courses. I also participated in a peer led IPA group with my fellow trainees and attended the East Midlands IPA group which met on a monthly basis. I found these resources useful in building my confidence in undertaking the analysis. The groups provided a sound understanding of the philosophical underpinnings of IPA and the difficulties for novice researchers undertaking analysis for the first time. They provided guidance on carrying out analysis which was true of the IPA approach.

The small sample size enabled me to examine transcripts over a period of time. The process began in October, 2014 and continued until the end of the first draft of my write up in April, 2015. The analysis went through a number of stages which began in a similar fashion to a general thematic analysis for each individual participant. I then looked at the language used by the participants and how they each constructed their stories. This led to emerging themes
being developed for each transcript. Once all interviews were analysed, I summarised each into 2/3 paragraphs and attempted to connect developing themes across interviews. This led to the first set of superordinate themes being developed.

I used supervision to discuss the themes as they were developing. This enhanced my confidence in capturing the phenomenological essence and to allow myself to bring my own interpretations into the analysis. I have an interest in how historical, cultural and societal ideas can influence discourse. This led me to bring in Habermas’s ideas, which had been previously used in studies with interpreters (Greenhalgh, 2006).

Through a series of reviews, using wall chart paper and post-it notes, the themes were reorganised and took shape. At this point I took a break from the analysis for two or three weeks. When I returned I chose to listen to the audio accounts in turn to see how each fitted in with my analysis. Some themes were then amalgamated or discounted in my efforts to accurately portray the experiences of each participant. Supervision and discussions in the IPA groups I was a member of encouraged me to recognise that there was no ‘right’ answer and to not feel constrained to look for one.

Write Up

The write up began with the methodology section. It then progressed on to writing the results section. I used the write up of the results as a continuation of the analysis. Due to word count constraints, I chose to focus on those themes which resonated mostly with the research question. Once the introduction and discussion were finished, I sent the first draft to my supervisor. This helped me to elaborate on some of the ideas within the paper to provide a fuller story of the research process.
Reflections on personal and professional development

My research diary entries at the beginning of the process highlighted my lack of knowledge of the interpreter’s role. Like many stakeholders, I minimised the emotional and psychological aspects of their work. Reading the literature began to change my thoughts on their role, but it was not until the first interview that I began to fully appreciate the tensions, difficulties and skill levels needed for interpreting. Choosing to do a qualitative piece of research allowed me to understand at a deeper level the experience of the participants and the contexts in which they work in.

My research experience prior to training was fairly limited compared to some other trainees. I had made attempts at conducting research in one of my roles as an assistant psychologist, but struggled with navigating the ethics process and underestimated the length of time involved. Unfortunately, I could not complete the previous piece of research, having moved to a new post. Therefore, this study was my first successful attempt at completing a piece of research within the NHS. It has given me an added appreciation for academic and clinical researchers and the efforts just to get research started.

Using an IPA approach was also a new way of working for me. Being a novice, I was anxious about doing it ‘right’ but over the course was encouraged to appreciate the importance of a researchers epistemological and ontological position when analysing with rich, qualitative research. I feel these experiences will stand me well for the future. Completing the study was a demanding process. I found setting myself deadlines and attainable goals to be of benefit. In addition, managing my time and the importance of self-care throughout the process aided my progress.

I have now much more appreciation for the work of interpreters. I am concerned that their voice is not heard due to clinicians and organisations choosing to not acknowledge their importance in the triadic relationship so often a key to change in mental health services. I can empathise with their
precarious situations, how this limits their own voice and can lead to disempowerment of the profession.

**Critiques and Limitations of Research**

There was the opportunity for a sample bias within the research. All participants were recruited from two interpreting services in one region of the UK. There is the potential for social desirability within the interviews which could have shaped the data. Social desirability could also have influenced my findings, as well as my epistemological position and personal reflections. These are openly expressed in the report.

There was little information as to the cultural brokerage within the interviews. This may have been due to interpreters assimilating themselves into the NHS system and wishing to be seen as part of it. The findings of this and previous research are fairly similar. Similarities would be expected; whilst every precaution was made during the analysis to ‘bracket’ pre-supposition and prior knowledge. I found Heidegger’s notion of ‘desein’ that the researcher is extrinsically involved in the world and the research (Smith et al., 2009) was useful throughout the research. Supervision and continuous reflection were used to help myself engage with the data and acknowledge my own input but keeping the analysis rooted within the data.

**Dissemination**

I will be offering to disseminate my findings to interpreting and mental health services. I plan to write a summary report of the research for policy makers and commissioners. I also plan to publish the research in journal articles and to speak at conferences. I will also consult with my supervisors to identify other avenues of dissemination.
Future research opportunities

Future research looking into the content of sessions with interpreters would be beneficial. This would focus on how the triadic relationship is developed and maintained by all three parties involved. Future research looking at other ethnicities and how they experience the interpreting process would be of interest. Other research that would be of benefit could include participative action research with interpreters taking the lead. This could highlight issues with their role and as a group highlight areas where they feel disempowered.

Conclusion

To conclude, I found the research personally enriching, despite the demands and constraints involved. I found the process to be a positive learning experience which can be used as a platform for future research endeavours. I have developed competencies of conducting research at a doctoral level, successfully completing the ethics process; conducting research with a group I was largely unfamiliar with; completing the project to a set timescale; making use of supervision to overcome various challenges along the way; and writing up a thesis.

I hope the process, as well as the content, will inform my future practice and allow me to further improve my role in relation to working with multi-disciplinary staff and service users.

References


Appendices
Appendix A: Guidelines to authors for journal targeted for literature review

Instructions for authors

This journal uses ScholarOne Manuscripts (previously Manuscript Central) to peer review manuscript submissions. Please read the guide for ScholarOne authors before making a submission. Complete guidelines for preparing and submitting your manuscript to this journal are provided below.

Use these instructions if you are preparing a manuscript to submit to International Journal of Culture and Mental Health. To explore our journals portfolio, visit http://www.tandfonline.com/, and for more author resources, visit our Author Services website.

International Journal of Culture and Mental Health considers all manuscripts on the strict condition that

- the manuscript is your own original work, and does not duplicate any other previously published work, including your own previously published work.
- the manuscript has been submitted only to International Journal of Culture and Mental Health; it is not under consideration or peer review or accepted for publication or in press or published elsewhere.
- the manuscript contains nothing that is abusive, defamatory, libellous, obscene, fraudulent, or illegal.

Please note that International Journal of Culture and Mental Health uses CrossCheck™ software to screen manuscripts for unoriginal material. By submitting your manuscript to International Journal of Culture and Mental Health you are agreeing to any necessary originality checks your manuscript may have to undergo during the peer-review and production processes.

Any author who fails to adhere to the above conditions will be charged with costs which International Journal of Culture and Mental Health incurs for their manuscript at the discretion of International Journal of Culture and Mental Health’s Editors and Taylor & Francis, and their manuscript will be rejected.

This journal is compliant with the Research Councils UK OA policy. Please see the licence options and embargo periods here.

Contents List

Manuscript preparation

1. General guidelines
2. Style guidelines
3. Figures
4. Publication charges
Manuscript preparation

1. General guidelines
Manuscripts are accepted in English. Quotations of text fragments in other languages should be translated. Any consistent spelling and punctuation styles may be used. Please use single quotation marks, except where ‘a quotation is “within” a quotation’. Long quotations of 40 words or more should be indented without quotation marks.

- A typical manuscript will not exceed 4000 words for an empirical article, 6000 words for a review, or 5000 words for a theoretical article, excluding tables, references, captions, footnotes and endnotes. Manuscripts that greatly exceed this will be critically reviewed with respect to length. Authors should include a word count with their manuscript.
- Manuscripts should be compiled in the following order: title page (including Acknowledgements as well as Funding and grant-awarding bodies); abstract; keywords; main text; acknowledgements; references; appendices (as appropriate); table(s) with caption(s) (on individual pages); figure caption(s) (as a list).
- Please supply all details required by any funding and grant-awarding bodies as an Acknowledgement in a separate Funding paragraph, as follows:
  - For single agency grants: "This work was supported by the <Funding Agency> under Grant <number xxxx>.".
  - For multiple agency grants: "This work was supported by the <Funding Agency #1> under Grant <number xxxx>; <Funding Agency #2> under Grant <number xxxx>; and <Funding Agency #3> under Grant <number xxxx>.".
- Abstracts of no more than 200 words are required for all manuscripts submitted.
- Each manuscript should have 5 to 7 keywords.
- Search engine optimization (SEO) is a means of making your article more visible to anyone who might be looking for it. Please consult our guidance here.
- Section headings should be concise. If numbering is required, use a decimal system for subsections.
- All authors of a manuscript should include their full names, affiliations, postal addresses, telephone numbers and email addresses on the cover page of the manuscript. One author should be identified as the corresponding author. Please give the affiliation where the research was conducted. If any of the named co-authors moves affiliation during the peer review process, the new affiliation can be given as a footnote. Please note that no changes to affiliation can be made after the manuscript is accepted. Please note that the email address of the corresponding author will normally be displayed in the article PDF (depending on the journal style) and the online article.
• All persons who have a reasonable claim to authorship must be named in the manuscript as co-authors; the corresponding author must be authorized by all co-authors to act as an agent on their behalf in all matters pertaining to publication of the manuscript, and the order of names should be agreed by all authors.
• Please supply a short biographical note for each author.
• Authors must also incorporate a Disclosure Statement which will acknowledge any financial interest or benefit they have arising from the direct applications of their research.
• For all manuscripts, non-discriminatory language is mandatory. Sexist or racist terms must not be used.
• Authors must adhere to SI units. Units are not italicised.
• When using a word which is or is asserted to be a proprietary term or trade mark, authors must use the symbol ® or TM.
• Authors must not embed equations or image files within their manuscript

2. Style guidelines
Description of the Journal’s article style.

• Description of the Journal’s reference style.
• An EndNote output style is available for this journal.
• Guide to using mathematical scripts and equations.
• Word templates are available for this journal. If you are not able to use the template via the links or if you have any other template queries, please contact authortemplate@tandf.co.uk.

3. Figures
Please provide the highest quality figure format possible. Please be sure that all imported scanned material is scanned at the appropriate resolution: 1200 dpi for line art, 600 dpi for grayscale and 300 dpi for colour.

• Figures must be saved separate to text. Please do not embed figures in the manuscript file.
• Files should be saved as one of the following formats: TIFF (tagged image file format), PostScript or EPS (encapsulated PostScript), and should contain all the necessary font information and the source file of the application (e.g. CorelDraw/Mac, CorelDraw/PC).
• All figures must be numbered in the order in which they appear in the manuscript (e.g. Figure 1, Figure 2). In multi-part figures, each part should be labelled (e.g. Figure 1(a), Figure 1(b)).
• Figure captions must be saved separately, as part of the file containing the complete text of the manuscript, and numbered correspondingly.
• The filename for a graphic should be descriptive of the graphic, e.g. Figure1, Figure2a.

4. Publication charges

Submission fee
There is no submission fee for *International Journal of Culture and Mental Health*.

**Page charges**

There are no page charges for *International Journal of Culture and Mental Health*.

**Colour charges**

Colour figures will be reproduced in colour in the online edition of the journal free of charge. If it is necessary for the figures to be reproduced in colour in the print version, a charge will apply. Charges for colour figures in print are £250 per figure ($395 US Dollars; $385 Australian Dollars; 315 Euros). For more than 4 colour figures, figures 5 and above will be charged at £50 per figure ($80 US Dollars; $75 Australian Dollars; 63 Euros).

Depending on your location, these charges may be subject to Value Added Tax.

5. Reproduction of copyright material

If you wish to include any material in your manuscript in which you do not hold copyright, you must obtain written permission from the copyright owner, prior to submission. Such material may be in the form of text, data, table, illustration, photograph, line drawing, audio clip, video clip, film still, and screenshot, and any supplemental material you propose to include. This applies to direct (verbatim or facsimile) reproduction as well as “derivative reproduction” (where you have created a new figure or table which derives substantially from a copyrighted source).

You must ensure appropriate acknowledgement is given to the permission granted to you for reuse by the copyright holder in each figure or table caption. You are solely responsible for any fees which the copyright holder may charge for reuse.

The reproduction of short extracts of text, excluding poetry and song lyrics, for the purposes of criticism may be possible without formal permission on the basis that the quotation is reproduced accurately and full attribution is given.

For further information and FAQs on the reproduction of copyright material, please consult our Guide.

7. Supplemental online material

Authors are encouraged to submit animations, movie files, sound files or any additional information for online publication.
Appendix B: Inclusion/exclusion criteria

The following inclusion and exclusion criteria were applied.

*Inclusion:* Studies which have primary data (quotations) available from foreign language interpreters experiences; qualitative methodology; professional interpreter focussed (specific paid role as interpreter); focus on experience of interpreter; related to working in mental health; peer reviewed article; published after 2000; Papers published in English.

*Exclusion Criteria:* Quantitative methodology; Studies not published in peer review journals (i.e. book chapter, opinion pieces, thesis); other literature reviews were excluded as were professional opinions; letters and non-studies; Studies relating to British Sign Language (BSL) interpreters for Deaf people; papers which related to linguistic theory were also excluded.

Grey literature was not considered in the current review due to the difficulties in measuring the extent and quality of studies in such an extended search. Therefore, PHD dissertations and book chapters were not included in the results section. It was felt by the reviewer that being transparent in the search strategy could give a constructive critique of the reviews findings and limitation. Including grey literature can be seen as problematic as there is less scope for interpreting quality of the studies. Furthermore, those academic papers which only included unpaid or informal interpreters were excluded from the search as Searight & Armock (2013) highlights how these interpreters can produce more linguistic errors when compared to paid interpreters.
Appendix C: Table 1 showing results of 10 searches

<table>
<thead>
<tr>
<th>Search Code</th>
<th>Database of Search</th>
<th>Key Words used</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>1a</td>
<td>PsychINFO</td>
<td>Interpreter, Mental health,</td>
<td>204</td>
</tr>
<tr>
<td>1b</td>
<td>PsychINFO</td>
<td>Interpreter, Psycholog* (y/ical)</td>
<td>346</td>
</tr>
<tr>
<td>1c</td>
<td>PsychINFO</td>
<td>Interpreter, Therapy,</td>
<td>137</td>
</tr>
<tr>
<td>1d</td>
<td>PsychINFO</td>
<td>Interpreter, Counsel*,</td>
<td>115</td>
</tr>
<tr>
<td>1e</td>
<td>PsychINFO</td>
<td>Mental Health, interpreting, language</td>
<td>66</td>
</tr>
<tr>
<td>2a</td>
<td>Web of Science databases</td>
<td>Interpreter, Mental health,</td>
<td>144</td>
</tr>
<tr>
<td>2b</td>
<td>Web of Science databases</td>
<td>Interpreter, Psycholog* (y/ical)</td>
<td>439</td>
</tr>
<tr>
<td>2c</td>
<td>Web of Science databases</td>
<td>Interpreter, Therapy,</td>
<td>207</td>
</tr>
<tr>
<td>2d</td>
<td>Web of Science databases</td>
<td>Interpreter, Counsel*,</td>
<td>68</td>
</tr>
<tr>
<td>2e</td>
<td>Web of Science databases</td>
<td>Mental Health, interpreting, language</td>
<td>79</td>
</tr>
</tbody>
</table>

Total Number of Articles: 1805
Total Number of articles related to the question (title and abstract level): 43
Total Number of Duplicates: 12

From those articles which were relevant to the question when paper was read: 21

Total Number studies: 9
# Appendix D - Shortlisted papers which were excluded

<table>
<thead>
<tr>
<th>Paper Number</th>
<th>Author (Date)</th>
<th>Title</th>
<th>Reason for Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Stapleton et al. (2013)</td>
<td>Lost in translation: Staff and interpreters’ experiences of the Edinburgh Postnatal Depression Scale with women from refugee backgrounds.</td>
<td>Research closer to a participative action research, where the interpreters were the researcher and ‘participants’ were the patients.</td>
</tr>
<tr>
<td>2</td>
<td>Smith et al. (2013)</td>
<td>Mediating words, mediating worlds: Interpreting as hidden care work in a South African psychiatric institution.</td>
<td>Participants were informal interpreters.</td>
</tr>
<tr>
<td>4</td>
<td>McDowell et al. (2011)</td>
<td>The work of language interpretation in health care: Complex, challenging, exhausting, and often invisible.</td>
<td>Study was based in physical health care setting.</td>
</tr>
<tr>
<td>5</td>
<td>Leanza et al. (2010)</td>
<td>Interruptions and resistance: A comparison of medical consultations with family and trained interpreters.</td>
<td>Study was based in physical health care setting.</td>
</tr>
<tr>
<td>6</td>
<td>Hsieh (2010)</td>
<td>Provider–interpreter collaboration in bilingual health care: Competitions of control over interpreter-mediated interactions.</td>
<td>Study was based in physical health care setting.</td>
</tr>
<tr>
<td>7</td>
<td>White et al. (2009)</td>
<td>Role exchange in medical interpretation.</td>
<td>Study was based in physical health care setting.</td>
</tr>
<tr>
<td>8</td>
<td>Rosenberg et al. (2008)</td>
<td>Through interpreters' eyes: Comparing roles of professional and family interpreters.</td>
<td>Study was based in physical health care setting.</td>
</tr>
<tr>
<td>9</td>
<td>Dysart-Gale et al. (2007)</td>
<td>Clinicians and medical interpreters: Negotiating cultural appropriate care for patients with limited English ability.</td>
<td>Study was based in physical health care setting.</td>
</tr>
<tr>
<td>10</td>
<td>Hsieh (2006)</td>
<td>Conflicts in how interpreters manage their roles in provider-patient interactions.</td>
<td>Study was based in physical health care setting.</td>
</tr>
<tr>
<td>11</td>
<td>Hudelson (2005)</td>
<td>Improving patient-provider communication: Insights from interpreters.</td>
<td>Study was based in physical health care setting.</td>
</tr>
<tr>
<td>14</td>
<td>Kritzinger et al. (2014)</td>
<td>“I just answer 'yes' to everything they say”: Access to health care for deaf people in Worcester, South Africa and the politics of exclusion.</td>
<td>Participants were informal interpreters and study based in physical health care settings.</td>
</tr>
<tr>
<td></td>
<td>Authors</td>
<td>Title</td>
<td>Setting/Focus</td>
</tr>
<tr>
<td>---</td>
<td>--------------------------</td>
<td>----------------------------------------------------------------------</td>
<td>------------------------------------------------</td>
</tr>
<tr>
<td>15</td>
<td>Norström et al. (2012)</td>
<td>Working conditions of community interpreters in Sweden: Opportunities and shortcomings.</td>
<td>Study was based in physical health care setting.</td>
</tr>
<tr>
<td>16</td>
<td>Kilian et al. (2010)</td>
<td>Competence of interpreters in a South African psychiatric hospital in translating key psychiatric terms.</td>
<td>Study was based in physical health care setting.</td>
</tr>
<tr>
<td>17</td>
<td>Hsieh (2008)</td>
<td>'I am not a robot!' Interpreters' views of their roles in health care settings.</td>
<td>Study was based in physical health care setting.</td>
</tr>
<tr>
<td>20</td>
<td>Rosenberg et al. (2007)</td>
<td>Doctor-patient communication in primary care with an interpreter: Physician perceptions of professional and family interpreters.</td>
<td>Study was based in physical health care setting.</td>
</tr>
</tbody>
</table>
## Appendix E: Data Extraction Proforma

<table>
<thead>
<tr>
<th>Article Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title:</td>
</tr>
<tr>
<td>Author (1st only):</td>
</tr>
<tr>
<td>Publication Date</td>
</tr>
<tr>
<td>Journal:</td>
</tr>
<tr>
<td>Volume: Number: Pages:</td>
</tr>
<tr>
<td>Country of Study:</td>
</tr>
<tr>
<td><strong>Aims</strong> <em>(clearly stated aims; context; rational)</em></td>
</tr>
<tr>
<td><strong>Participants &amp; Sampling</strong> <em>(age, sample size; gender; recruitment; response rate; ethical issues)</em></td>
</tr>
<tr>
<td><strong>Study Design</strong> <em>(clearly stated methodology; does it address question)</em></td>
</tr>
<tr>
<td><strong>Outcomes and measures</strong> <em>(methods; saturation point)</em></td>
</tr>
<tr>
<td><strong>Analysis</strong> <em>(methodology; descriptive or interpretative; results address question; quotation used)</em></td>
</tr>
<tr>
<td><strong>Findings</strong> <em>(clear statement of findings; reflexivity; theoretical standpoint)</em></td>
</tr>
<tr>
<td><strong>Quality of paper</strong> <em>(strategy to establish reliability, (inter-coder reliability); validity; clarity of presentation; appropriate methods)</em></td>
</tr>
<tr>
<td><strong>Conclusions</strong> <em>(what do the findings suggest; limitations; implications; appropriateness of methods)</em></td>
</tr>
<tr>
<td><strong>Additional Comments</strong> <em>(key strengths/limitations)</em></td>
</tr>
</tbody>
</table>
Appendix F: Description, critical appraisal and synthesis

All of the articles were screened using the data extraction table. This data extraction table was developed specifically for qualitative studies. The table was used as a quality assessment, to examine and critique the literature in order to aid the written synthesis shown in the results section and appendix I.

The critical appraisal involved two main parts. The first was a critique of quality of each study. This was in order to highlight the quality of each studies and as a whole body of text. It is recognised by the author that assessing for quality in qualitative studies is difficult and debated. There seems to be little consensus regarding how quality can be assessed (Thomas and Harding, 2008). The reviewer took the view that only those studies which could show direct input from interpreters could be included.

Quality was also assessed in terms of how appropriate methods were for addressing the research question; descriptive and interpretative descriptions of the data, how the results address the research question; information regarding saturation point; consideration of ethical issues; inter-coder reliability; clear statement of findings; reflexivity of authors regarding findings and their own position, theoretical standpoint; inclusion of quotation to evidence assertions made, type of analysis used.

Other criteria from Thompson and Harding (2008) included 12 themes broken into three sections. The first being the quality of reporting study’s aims, context, rational, methods and findings. Secondly, sufficiency of strategies employed to establish the reliability and validity of data collection tools and methods of analysis. Finally, the appropriateness of methods with regards to the research question. The second part of the critical appraisal was the thematic synthesis of each study’s findings.
Appendix G: Thematic Synthesis (overview)

It was felt that the studies found in the systematic electronic and manual search were sufficient to carry out a thematic synthesis of the literature. The reviewer felt that due to the similar themes within the studies collected that the data could have been considered to reaching a conceptual saturation point in the literature, related to the research question. Conceptual saturation is a similar concept to data saturation in first hand qualitative research, which is where the findings will not differ if there are further papers or data included in the study (Thomas and Harding, 2008). However, as no studies relating to the research question were excluded the conceptual saturation point is unknown. Therefore, this is a limitation to the review.

A thematic synthesis can be used to generate hypotheses which can later be tested in relation to findings of quantitative studies (Thomas and Harding, 2008). The review aims to give an aggregated account of the literature and does not seek to further interpret this.

As per Thomas and Harding (2008) the reviewer looked for differences and similarities between codes developed from each study. New codes were then created to capture the meanings of these initial codes. At this stage the codes remain largely descriptive. Following this stage, a more analytical stage of generating overarching themes is developed. The reviewer recognises this is depending on judgement and insights of the reviewer. This is a cyclical process, referring back to the papers themselves, initial codes and emergent themes in each and across each study.
Description and overview of studies.

The details in the analysis, focuses only on the elements of the paper which relate to interpreters experience.

Bercher & Wieling (2014) examined how interpreters and clinicians work together in delivering care and how interpreters relate to therapists and clients. The study focused on how elements of power and privilege impact relationship dynamics between therapist and interpreters. Using a snowball sampling technique, they interviewed 10 interpreters. There was a gender bias of nine female, whilst length of experience was between 3 and 30 years. Participants were also either agency or onsite staff within mental health services. Using an Ethnographic Developmental research sequence (Spradley, 1980) this exploratory study highlighted the dynamic nature and power between clinicians and interpreters within the triadic working relationship. The study highlighted the importance of relationships in facilitating positive outcomes for clients; how familiar working helps the interpreting process; how clinicians can use power inappropriately whilst interpreters underestimate their own power when working with clinicians. Interviews were analysed by more than one researcher, member checking and self reflection occurred throughout the research process. It was difficult to distinguish between therapist and interpreter themes within the paper.

Splevin et al. (2012) investigated the experience of interpreters working with trauma survivors, with a specific focus on Vicarious Post Traumatic Growth (VPTG). A purposive sample was utilised to conduct semi-structured interviews. Eight interpreters were interviewed (six women, two men) who were aged between 30 and 64 year old and worked as freelance interpreters. The study drew upon Interpretative Phenomenological Analysis (IPA). The use of auditing and self-reflection aided the validity of the findings. Splevin et al. (2012) highlights how interpreters can identify with clients and enmeshment can exacerbate distress for interpreters. Interpreters use a range of strategies to
cope; overtime distress can diminish with interpreters developing professionally and personally through their role. The sample was biased to those interpreters who could cope with the role long enough to be interviewed, one interpreter did continue to show signs of distress and distrust.

Doherty et al. (2010) surveyed interpreters to explore the impact of mental health interpreting and how they cope with their role. Semi-structured questionnaires were sent to interpreters (n = 157), with a 13% response rate. Grounded Theory (Pidgeon and Henwood, 1996) was utilized to analyse the findings. The study highlights mental health interpreting as being a challenging and emotionally demanding occupation. This can have an impact on the interpreter’s personal and professional life. This study may have been biased by the low response rate. It was also unclear if interpreters worked with refugees/asylum seekers and/or economic migrants.

Holmgreen et al. (2003) explored the background and work of twelve Kosovo-Albanian interpreters at the Danish Red Cross. Using a Grounded Theory (Strauss and Corbin, 1990) approach, the study focused on the working conditions of interpreters as well as the perceived difficulties and strains of their work. Ten of the interpreters were employed on a permanent basis whilst two worked as freelance. In total eight men and four women were interviewed. The study found interpreters to be exhausted due to the stressful, demanding and psychologically degrading working conditions they experienced. There was limited information regarding reflexivity of authors or inter-coder reliability within the analysis.

d’Ardenne et al. (2007) described the development of protocols with interpreters employed in a psychological trauma clinic. The aim was to identify consistent good practice in working with traumatised patients. An interpreting service director and three of the most experienced interpreters took part in a semi-structured focus group to discuss their experiences working with the clinic. The study highlighted the limited mental health training of interpreters, how emotions can influence their work; their fear of re-traumatisation and
professor burnout. A small number of interpreters were included, but formed a useful part in the development of protocols for the clinic.

Johnson et al. (2009) explored how the role of being an interpreter was experienced by people who had themselves suffered trauma. A purposive sample was utilised in line with other IPA research. A total of nine interpreters were interviewed (six male and three female aged from 24 to 46 years old). The research was audited by a second researcher and themes were evidenced within the data. The research highlights how interpreting may help both interpreters and clients to normalise and appraise their own experience. The role of interpreting may also help to maintain cultural identity. One limitation was the author’s difficulties in defining what ‘non-western’ interpreting actually means.

Mirdal et al. (2012) investigated how traumatised refugees, their therapist, and their interpreters perceive psychological therapy, in particularly the curative and hindering factors of the process. Eight interpreters were interviewed regarding specific cases they had worked with; some interpreters were interviewed more than once. In total 16 cases were included in the paper, chosen for being most/least successful cases within a rehabilitation service for traumatised refugees. There were no details regarding gender, age or amount of experience amongst the interpreters. The study adopted Giogi’s (1985) qualitative phenomenological approach as their method of analysis. Details of the researcher reflection process were included, inter-coder reliability was discussed as well as the benefits and limits of collecting naturalistic data. The study commented on the strong personal commitment by professionals as being of value. Compassion, becoming overwhelmed, the relationships within the triad, good working alliance, trust, psychoeducation, and external factors aware considered as a positive influence to therapeutic outcomes.

Miller et al. (2005) presented a narrative study which examined the use of interpreters in psychotherapy with refugees. A total of 15 interpreters were interviewed, the vast majority were male and came from Eastern European countries. Semi-structured interviews took place in person and over the phone.
Inter-coder reliability was measured across researcher and taken into account in the final analysis. The study highlighted how interpreters can be used as 'cultural consultants' but complex emotional reactions may arise within the therapy triad which can effect interpreters own well-being.

Green et al. (2012) used an IPA approach to explore Kurdish refugee interpreter’s experience of working in UK mental health services. A purposive sample was utilised and six participants (four male; two female; aged between 31 and 55) were recruited. Interpreters all had at least four years interpreting experience. The researchers provided an account of their ongoing self-reflection throughout the study and a process of auditing by an independent researcher. Commenting on the emotional reaction to the interpreting role, the authors recommended interpreters have support throughout the careers which reflects their specific needs at specific times.

Butler (2008) investigated how interpreters make sense of and cope with interpreting accounts of sexual violence. A purposive sample was utilised for this IPA study with three female interpreters. Interpreters had between four and ten years experience and were aged between 25 and 55 years old. In this short paper little information was given on the authors epistemological stance or inter-coder reliability. The study did illuminate the emotional impact of interpreting, interpreter’s reactions to client accounts; identifying with clients, becoming overwhelmed or distancing themselves. The lack of support, which can impact on the working alliance within the triad was also discussed.

Resera et al.’s (2014) exploratory study using a grounded theory approach (Strauss and Corbin, 1990) reported on interpreters who work with ‘recent’ migrants, mainly refugees and asylum seekers. The study analysed the dynamics of interpreter-mediated psychotherapeutic encounters from the point of view of interpreters. Twelve interpreters took part in semi-structured focus groups. The study highlighted complex issues when interpreting in mental health which are not reflected within the interpreter’s professional guidelines or support network.
### Appendix I: Thematic Analysis: Breakdown of themes per article.

<table>
<thead>
<tr>
<th></th>
<th>Enhanced role</th>
<th>Emotional impact</th>
<th>Relationship matters</th>
<th>Bearing Witness</th>
<th>Coping (trial and error)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Becher &amp; Wieling (2014)</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Splevins et al. (2012)</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Doherty et al. (2010)</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Holmgreen et al. (2003)</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>D’Ardenne et al. (2007)</td>
<td>x</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Johnson et al. (2009)</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Mirdal et al. (2012)</td>
<td>x</td>
<td></td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Miller et al. (2005)</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Green et al. (2012)</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Butler (2008)</td>
<td></td>
<td>x</td>
<td>x</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Resera et al. (2014)</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix J: Statement of epistemological position

The current study was conducted within the epistemological framework of 'critical realism' positioned within social constructionism (Harper, 2012). The study attempts to understand what being an interpreter within a mental health context was really like for participants.

Pilgrim (2014) describes critical realism as a philosophical position which can be traced back to both Durkheim and Karl Marx. Critical Realism aims to put the focus on being rather than knowing. Critical realism recognises that values and context are embedded in all scientific enquiry. It posits that science should be subjected to ideological reflection as well as logical reflection. These aspects of critical realism are important for social science to take into account due to the enquirer being part of the object of enquiry, as we are all social beings (Bhaskar, 1997, 1998). The epistemological position recognises the awareness of the importance of studying the qualitative data, but also places an importance on going beyond the text to position the text within its broader historical, cultural and social contexts (Harper, 2012). As Willig (in press) points out this position is concerned with the constraints of the discourse and limits of the data within its particular context.

The current study, takes critical realism as its ontological position, recognising the values and context which the current study as well as the participants existence into account when analysing the data gathered. Therefore the analysis will incorporate proximal and distal factors which influence their experiences.
University of Leicester Ethics Review Sign Off Document

To: COLM GALLAGHER

Subject: Ethical Application Ref: cg222-1188

(Please quote this ref on all correspondence)

27/06/2014 11:55:37

Psychology

Project Title: Exploring the experience of Polish interpreters who translate for mental health professionals: An Interpretative Phenomenological Analysis

Thank you for submitting your application which has been considered.

This study has been given ethical approval, subject to any conditions quoted in the attached notes.

Any significant departure from the programme of research as outlined in the application for research ethics approval (such as changes in methodological approach, large delays in commencement of research, additional forms of data collection or major expansions in sample size) must be reported to your Departmental Research Ethics Officer.

Approval is given on the understanding that the University Research Ethics Code of Practice and other research ethics guidelines and protocols will be compiled with

• http://www2.le.ac.uk/institution/committees/research-ethics/code-of-practice

• http://www.le.ac.uk/safety/
Appendix L: Notification of Sponsorship from University of Leicester

Electronic Authorisation Given

From: IRAS [ithelpdesk@infonetica.co.uk]

To: Gallagher, Colm

21 August 2014 12:06

Dear Mr Colm Gallagher

**** ******* has given electronic authorisation as Sponsor’s representative for Project “Experience of Polish interpreters who translate for mental health.”.

If you need further help or assistance please e-mail us at: helpdesk@infonetica.net or phone 0207 099 2015.

Regards
Integrated Research Application System
https://www.myresearchproject.org.uk/

This is a system-generated e-mail. Please do not reply.
28 August 2014

Mr Colm Gallagher
Clinical Psychology Department
University of Leicester

Dear Mr Colm Gallagher

Study: 0470
Exploring the experience of Polish interpreters who translate for mental health professionals: An Interpretative Phenomenological Analysis
Site: 
PI at Site: Mr Colm Gallagher

I am pleased to advise you that following confirmation of a Favourable Opinion from an Ethics Committee, NHS Trust R&D Approval and where relevant regulatory authority agreements have been received, the University are able to confirm sponsorship for the above research at the Site.

Please note you are required to notify the Sponsor and provide copies of:

- Changes in personnel to the Study
- Changes to the end date
- All substantial amendments and provisional and favourable opinions
- All minor amendments
- All serious adverse events (SAES) and SUSARS
- Annual progress reports
- Annual MHRA (DSUR) safety reports (if applicable)
- End of study declaration form
- Notifications of significant breaches of Good Clinical Practices (GCP) or Protocol

Please copy the Sponsor into all correspondence and emails by using:

I would like to wish you well with your study and if you require further information or guidance please do not hesitate to contact me.

Yours sincerely
8th September 2014

Mr Colm Gallagher
Clinical Psychology Department
University of Leicester

Dear Mr Colm Gallagher

Study No: 0470
Study Title: Exploring the experience of Polish interpreters who translate for mental health professionals: An Interpretative Phenomenological Analysis
Site:

I am pleased to advise you that following all necessary approvals being in place, the University are now able to confirm Sponsor Green Light approval at the above site.

I would be grateful if you can forward a copy of this letter to the Principal Investigator for their site file.

Please copy the Sponsor into all correspondence and emails by using

If you require further information or guidance please do not hesitate to contact me.

Yours sincerely
Appendix M: Letters to and from NHS Research and Development committees

Mr Colm Gallagher
Trainee Clinical Psychologist
c/o University of Leicester
104 Regent Road
Leicester LE1 7LT

Dear Colm

RE: Exploring the experience of Polish interpreters who translate for mental health professionals: An Interpretative Phenomenological Analysis

Thank you for applying for NHS Permission to conduct recruitment for the above study within Leicestershire Partnership NHS Trust. This study has now been validated and reviewed according to the Standard Operating Procedure for research appraisal. Leicestershire Partnership NHS Trust has granted you full approval to conduct this research within the Trust on the condition that the Trust suffers no unforeseen costs as a result of this study being undertaken. Your research has been entered onto the Trust’s Research Database.

As this study falls outside the requirements for NHS Research Ethics Review, I am content to accept the favourable opinion of the Leicester University Ethics process as valid and proportionate. This approval is subject to there being a contract in place between the University of (__________) and NHS Trust; I understand that documentation to this effect will be provided from the office of (_______) in the near future. All research studies taking place in the NHS are now subject to monitoring in respect of NHS Permission timelines, recruitment to time and target and so on. As a result, some of this information is reproduced in the table below. The key monitoring target is a 70-day timeline from “NHS Permission”, within which the first patient or participant should be recruited (primarily for UKRN “Portfolio” Studies), please give due regard to this requirement and inform the R&D Office if this target is likely to be breached.

<table>
<thead>
<tr>
<th>APPROVAL STATUS</th>
<th>Approval in Principle</th>
<th>Approval refused</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Favourable Ethical Review (A)</td>
<td>27/06/2014</td>
<td></td>
</tr>
<tr>
<td>Date Full Documentation (Valid Application) Received (Site) (B)</td>
<td>29/07/2014</td>
<td>Sign-off timeline (A-B)</td>
</tr>
<tr>
<td>Date of Funding Agreement/SIV</td>
<td>TBA</td>
<td>22 Days</td>
</tr>
<tr>
<td>Date of Final NHS Permission (C)</td>
<td>31/07/2014</td>
<td>Sign-off timeline (B-C)</td>
</tr>
<tr>
<td>Target Date: First Patient/Participant Visit (FFPV)</td>
<td>10th October 2014</td>
<td>2 Days</td>
</tr>
</tbody>
</table>

The conduct of your study (including examination of the site file) at this site may be subject to audit for protocol adherence and other monitoring. This approval is subject to the accuracy of the following information:

1 Underline as appropriate
Study Summary

Chief Investigator (Supervisor): Dr Steve Melhuish
Principal Investigator (Local): Mr Colm Gallagher
Other Investigators: Dr Saima Masud
Indemnity Provider: University of Leicester & NHS Indemnity
NIHR Portfolio: No
Student Project: YES (DClinPsych)
Funding Source: University of Leicester

Local NHS Support Costs: Not applicable as non-portfolio
Start Date (Local): 01/08/2014
End Date (Local): 30/04/2015
Target Recruitment: 12
Amount: £300 (Student budget)

The table below lists the documentation listed as approved for use in this study. Any changes to this may require an amendment notification to the Research Ethics Committee and/or Research Office.

Approved Documentation

<table>
<thead>
<tr>
<th>Title</th>
<th>Version Number</th>
<th>Date</th>
<th>Date REC Approval</th>
</tr>
</thead>
<tbody>
<tr>
<td>Principal Investigator CV (Colm Gallagher)</td>
<td>N/A</td>
<td>July 2014</td>
<td>N/A</td>
</tr>
<tr>
<td>IRAS Form</td>
<td>N/A</td>
<td>04/07/2014</td>
<td>N/A</td>
</tr>
<tr>
<td>Participant Consent Form</td>
<td>2</td>
<td>25/07/2014</td>
<td>N/A</td>
</tr>
<tr>
<td>Supervisor CV (Dr. Stephen Melhuish)</td>
<td>N/A</td>
<td>2014</td>
<td>N/A</td>
</tr>
<tr>
<td>Interview Schedule</td>
<td>1</td>
<td>July 2014</td>
<td>N/A</td>
</tr>
<tr>
<td>Participant Information Sheet</td>
<td>2</td>
<td>25/07/2014</td>
<td>N/A</td>
</tr>
<tr>
<td>Research Protocol</td>
<td>1</td>
<td>05/07/2014</td>
<td>N/A</td>
</tr>
<tr>
<td>Confirmation E-Mail (Bini Gataure, UJala Resource Centre Manager)</td>
<td>N/A</td>
<td>27/06/2014</td>
<td>N/A</td>
</tr>
<tr>
<td>Confirmation of Sponsorship (University of Leicester: Wendy Gamble)</td>
<td>N/A</td>
<td>29/07/2014</td>
<td>N/A</td>
</tr>
<tr>
<td>Confirmation of Ethical Approval (University of Leicester)</td>
<td>cg220-1188</td>
<td>27/06/2014</td>
<td>27/06/2014</td>
</tr>
</tbody>
</table>

Local Service Involvement

Trust Division: Enabling
Service: N/A
Locality (if known): N/A

Please note that all research with an NHS element is subject to the Research Governance Framework for Health and Social Care 2005. If you are unfamiliar with the standards contained in this document, or the LPT policies that reinforce them, you can obtain advice from the R&D Office or your Sponsor. You must stay in touch with the R&D Office during the course of the research project, particularly if...

- There is a change of Principal Investigator;
- To fulfill requirements for performance reporting;
- The project finishes (please complete a summary report form);
- Amendments are made, whether minor or substantial;
- Serious Adverse Events occur (adhere to local and Sponsor SOPs).

This is necessary to ensure that your indemnity cover is and remains valid. Should any issues arise that inhibit study delivery it is essential that you contact the R&D Office immediately. If patients or staff members are involved in an incident, you should also contact the Clinical Risk Manager and report as per Trust Policy.

Provision against NHS Costs: The Trust reserves the right to invoice the study team, in the unlikely event of any unexpected costs arising from this study, including, but not limited to:

- Staff Time attending interviews.
- Travel and administrative costs

I hope the project goes well, and if you need any help or assistance during its course, please do not hesitate to contact the Office.

Kind regards,

[Signature]

142
# NHS PERMISSION AGREEMENT

## Investigator Agreement & Responsibilities

<table>
<thead>
<tr>
<th>Trust Reference:</th>
<th>ADMH0684</th>
</tr>
</thead>
<tbody>
<tr>
<td>CSP Reference:</td>
<td>N/A</td>
</tr>
<tr>
<td>IRAS Reference:</td>
<td>N/A</td>
</tr>
<tr>
<td>Project Title:</td>
<td>Exploring the experience of Polish interpreters who translate for mental health professionals: An Interpretative Phenomenological Analysis</td>
</tr>
</tbody>
</table>

As Principal Investigator for this study I agree to the following:

- I understand the responsibilities of a Principal Investigator defined in the Research Governance Framework and agree to abide by these.
- I will ensure that the study does not proceed, and recruitment does not take place without written approval from the Research Office and all sites involved.
- Summary information about the study can be made available to publicly accessible systems and communications media, except where this would compromise the protection of intellectual property.
- I will assist with any audits or monitoring of research whether conducted by the Trust, sponsor, University (when acting as Sponsor), or regulatory authority. This includes maintenance and availability of a Master Site File.
- I will co-ordinate completion and submission of interim, annual and final reports according to funders, ethics committee and Trust requirements.
- I will ensure that the protocol and any subsequent changes to the study design are conveyed to and approved by the relevant authority, and where necessary are independently peer-reviewed and notified to the host Research Office.
- I will ensure that any serious adverse events (SAEs) are reported following the procedures set out if the Trust's policy on reporting research-related adverse events.
- I will notify the Research Office if there is any need or intention to change the principal investigator for the study (perhaps requiring a new honorary contract etc.)
- I will make every reasonable effort to disseminate the findings of the study, including through peer-reviewed publication, and will lodge a copy of any such publication with the Research Office.

Name: ........................................................................................................
(LOCAL) Principal Investigator

Signature: .............................................................................................. Date: ........................................

Note: The Principal Investigator may delegate some or all of the responsibilities listed above but they will remain accountable to the Chief Executive for the overall conduct of the study. Any delegation of responsibility must be explicit and documented as per Standard Operating Procedure.

Please return the signed agreement to the Research Office.
Date of NHS permission for research: 08/09/2014

Mr Colm Gallagher
Leicestershire Partnership Trust
University of Leicester
104 Regent Road
Leicester
LE1 7L1

Dear Colm

Study Title: Exploring the experiences of Polish interpreters who translate for mental health professionals
Sponsor: The University of Leicester

Thank you for submitting your project to the Trust’s Research Support Services. The project has now been given NHS permission by:

NHS permission for the above research has been granted on the basis described in the application form, protocol and supporting documentation. The documents reviewed were:

<table>
<thead>
<tr>
<th>Document</th>
<th>Version</th>
</tr>
</thead>
<tbody>
<tr>
<td>IRAS Forms</td>
<td>V2.0 25/07/2014</td>
</tr>
<tr>
<td>Consent Form</td>
<td>V1.0 05/07/2014</td>
</tr>
<tr>
<td>Protocol</td>
<td></td>
</tr>
<tr>
<td>Participant Information Sheet</td>
<td>V2.0 25/07/2014</td>
</tr>
<tr>
<td>Interview Schedule</td>
<td>V1.0</td>
</tr>
<tr>
<td>Service support</td>
<td></td>
</tr>
<tr>
<td>Sponsorship approval</td>
<td>29/07/2014</td>
</tr>
<tr>
<td>NHS to NHS proforma</td>
<td></td>
</tr>
<tr>
<td>CV</td>
<td>Colm Gallagher</td>
</tr>
<tr>
<td>CV</td>
<td>Stephen Meluish</td>
</tr>
</tbody>
</table>

Permission is granted on the understanding that the study is conducted in accordance with the Research Governance Framework, ICH GCP (ONLY if applicable), and NHS Trust policies and procedures available [http://information/policies-and-procedures/]. The research sponsor or the Chief Investigator, or the local Principal Investigator at a research site, may take appropriate urgent safety measures in order to protect research participants against any
Immediate hazard to their health or safety. The R&D office should be notified that such measures have been taken. The notification should also include the reasons why the measures were taken and the plan for further action. The R&D Office should be notified within the same time frame of notifying the REC and any other regulatory bodies. All amendments (including changes to the local research team) need to be submitted in accordance with guidance in IRAS.

Please note that the NHS organisation is required to monitor research to ensure compliance with the Research Governance Framework and other legal and regulatory requirements. This is achieved by random audit of research.

Yours Sincerely

CC:

Sponsor

Stephen Melluish
Appendix N: Additional ethical considerations

Informed Consent

Informed consent from participants will be gained verbally during the recruitment stage of the research and in writing prior to the interview taking place. The study aims and procedures will be made clear to all participants via the participant information sheet and subsequent conversations with the researcher before consent is gained.

Confidentiality of Participants

Information obtained about a participant during the study will remain confidential throughout all points of the research. Any names or identifiable information given by participants during any part of the research process will anonymised.

Confidentiality of Data

Participant information will be stored confidentially and the anonymity will be preserved by using pseudonyms in the transcriptions. Audio recordings will be stored on encrypted data sticks until transcribed, at which point they will be deleted.

Data Storage

Data collected will include the recorded interviews and transcription made. Immediately after the interview, the recording will be transferred onto an encrypted memory stick. All personal information will be anonymised and hard copies of information will be transferred securely and stored in a locked cupboard. Participants will be given a numerical code, in order for the researcher to identify data. Any personal data (i.e. consent forms, participant contact details) will be stored separately from the research data by the researcher. All effort will be made to ensure data is presented anonymously when disseminated, identifiable information will be removed. All electronic files will be password protected. On completion of the study all personal details will
be disposed of, an anonymised and confidential electronic version of the research data will be kept at the University of Leicester Clinical Psychology Department at 104 Regents Road, Leicester. This is in line with the University policy for data storage. Participants will be asked to sign a receipt for their voucher. This receipt shall be kept in a sealed envelope along with the research data in line with university auditing policy.

Debriefing

Following the interview participants will be debriefed and given the opportunity to ask any questions or have further clarification as the purpose and/or procedures of the study.

Protection of participants and right to withdraw

Participants can, and will be made aware they have the right to withdraw from the study at any time. It is not expected that participants will be at significant risk due to the nature of the study. However, some potentially sensitive issues relating to the participants experiences of interpreting in a mental health context may cause distress during the interview. Participants will be made aware that they can ask for a break or discontinue the interview at any point should they feel distressed. During any breaks the researcher will privately ensure the psychological and emotional needs of the participants are met. Time will be allocated at the end of the interview with the research to discuss any issues, questions or concerns which may have been raised during the interview process. In the event of a participant becoming distressed and ending the interview, any issues will be discussed with the participant, and where necessary the researcher shall attend to the individual and ensure their immediate needs are met. These needs shall be judged on a case by case basis, from advising the participant to seek support from their GP or employer to liaising with mental health services connected to the participant. This would depend on the level of risk assumed during the interview. Contact details of the researcher and academic supervisor will be provided to the participant should any later questions develop.
Appendix O: Topic Guide

**Individual background information**

1. How would you describe yourself as a person?  
   *Prompt: What are the most important things to know about you?*

2. How did you decide to become an interpreter in the UK?  
   *Prompt: What are the factors which led you to make the decision to choose this role?*  
   *Reason for moving to the UK, reason for taking the role*  
   *Did you have any formal training for this work?*

3. I am interested in what you understand by the term ‘mental health’ or ‘mental illness’ is there a comparable term in Polish?  
   *Prompt: From your understanding are there differences in how mental health is considered in Poland?*

**Understanding the role**

4. Can you tell me about what the role of interpreting for a mental health service user is like for you?  
   *Prompt: How do you prepare for the appointment? How do you see your role?*

5. Can you give me an example of what it is like to be in the room interpreting?  
   *Prompt: How do you negotiate the relationships, the processes involved, emotions, working with client and mental health professional.*

6. How do you think other mental health workers see the role of the interpreter in your service?

**Relationship(s)**

7. Can you tell me about your experience of the relationship between you and the mental health worker in a mental health context?  
   *Prompt: How do you negotiate the relationship? Do you have any examples of good/bad experiences?*

8. Can you tell me about your experiences of the relationship between you and a client you have interpreted for?  
   *Prompt: I am interested in how the client responds to you as someone who shares the same language as them? How do you react to this?*  
   *Do you have an example of an experience?*  
   *How do you respond when there are differences or dislikes of a client?*  
   *How do you respond in the appointment if you know the client from a different context, or if you know more about a client from a different context that what he/she discusses?*

**Experience of difficulties/positives within the role**

9. Have there ever been times in your work which has not gone as well as you would have liked (specific to mental health)? What were the factors which contributed to this?  
   *Prompt: Feelings/emotions – how does it leave you feeling? How do you manage the feelings that this brings up in you?*
How do you see similarities / differences with clients, does it affect your work?

10. How do you deal with these difficulties?
   Prompt: How do you find (or manage) the endings of your work with clients (after an appointment and series of appointments)?
   Do clients ask more of you (information, relationship building) following sessions?

11. Do you think you have gained anything from your role, on a personal as well as professional level?

   **Any further reflections upon the role as an interpreter**

12. Have you any further reflections on your role or what we have discussed?

**General Probes**
Can you say a bit more about the experience/feelings you have had?
   Could you say a bit more about that?
Is there anything else you would want to say about that?
Do you have any other examples of when x has happened?
Do you have ideas about...?
   What did you think of that? What does that mean for you? How did you make sense of that?
Appendix P: Participant Information Sheet

Exploring the experience of Polish interpreters who translate for mental health professionals: An Interpretative Phenomenological Analysis
Colm Gallagher, Trainee Clinical Psychologist

You are being invited to take part in a research study. Before you decide whether or not you wish to participate, it is important for you to understand why the study is being done and what it will involve. Please take the time to read the following information carefully and discuss it with others if you wish. Thank you for reading this.

What is the purpose of the study?

The study aims to interview interpreters who interpret for Polish individuals in a mental health context. The study is looking at understanding how interpreters experience their roles in translating in an adult mental health setting. The study also aims to understand how interpreters consider the relationship between themselves, the client and the mental health professional when interpreting in mental health settings.

Why have I been chosen?

Participants for the study were identified from Interpreting Services in the East Midlands area, who have interpreted for Polish individuals in a mental health setting.

Do I have to take part?

It is up to you to decide whether or not to take part. If you decide to take part you will be given this information sheet to keep and be asked to give your written consent. If you decide to take part you are still free to withdraw before, during or after the interview without giving a reason. Any information or responses you may have already given will be destroyed. A decision not to take part or to withdraw at any time will not affect your rights in any way.

Will I get paid to take part?

Participants will be offered a voucher worth £15 for taking part in the study. This will be given on completion of the interview.

When and Where will the study take place?

Once you have agreed to take part in the study a researcher will arrange to come to see you at a mutually convenient place and time in order to complete an interview. This will be arranged between you and the researcher. The interview should take no longer than an hour. You will be asked to give written consent for the interview to be audio recorded. Only one interview is required. If it is not possible to complete the interview in one appointment then the researcher will be happy to arrange to visit you again. Breaks can also be taken at any time throughout the interview.

There will be an opportunity after the interview to discuss with the researcher any questions you may have or any concerns relating to the interview. The information will be gathered to look at interpreters’ experiences of interpreting for Polish individuals in a mental health setting.
What do I have to do?
Taking part in this study means that you will be interviewed which will last for approximately one hour. You do not have to do anything else. Your regular activities and day-to-day routines will not be affected as much as possible.

What are the possible risks or disadvantages of taking part?
There are no risks involved in taking part but it is possible that talking about your experiences may cause you to feel upset or distressed. The researcher will therefore always offer the opportunity after the interview to discuss this with them and support will be provided if you have found it distressing in any way. A break can be asked for at any point within the interview.

What are the possible benefits of taking part?
We hope that this study will help you by discussing your experiences of interpreting for mental health service users and your role within such an environment. We are also hopeful that findings from the research may be used to help services be more sensitive to the needs of interpreters and inform future clinical practice.

What if something goes wrong?
If you wish to complain or have any concerns about any aspect of the way you have been approached or treated during the course of this study, the normal National Health Service complaints mechanisms are available to you.

Will my taking part in this study be kept confidential?
All information which is collected about you during the course of the study will be kept strictly confidential. All information recorded from you in the interview will not have any information attached to it that you could be recognised from. Interview data will be kept on encrypted computer hardware and will be destroyed five years following the study. Research data may also be looked at by responsible individuals from the Sponsor or the Trust Research and Development department for the purpose of monitoring or audit.

Audio tapes are treated in the same way as files, that is, they are confidential, will be stored securely and will only be listened to by specified people involved in this research project. Consent to an interview being audio recorded can be withdrawn up to two weeks post interview by anyone being recorded on the tape. In those instances, the audio tape will be erased and your rights will not be affected in any way.

All audio tapes will be stored in a secure locked environment during the course of the research project. Following completion of the research all tapes and data will be held in a locked room at the Clinical Psychology Base at the University of Leicester and will be destroyed after five years, in line with university regulations. There will be no identifying information on the tapes or transcripts of interviews being stored.

What will happen to the results of the study?
The results of this study will be available in 2015-2016. The results will form the researcher’s doctoral thesis and is expected to be published in a peer-reviewed journal. All information will be anonymised and non-identifiable. A copy of the collected results will be sent to interested organisation. If any participants wish to receive a report about the study’s findings they can inform the researcher at the time of the interview.

Who is organising the study
The research is organised by Leicestershire Partnership NHS Trust and has obtained NHS permission and Research and Development approval.

If you have any questions or would like more information about the study please contact one of the researchers on the following numbers:
Please note that this form will be kept separately from your data
Appendix Q: Written Consent Form

Version 2: 25/07/2014

Centre Number:
Study Number:
Participant Identification Number for this trial:

Consent Form

Title of Project: Exploring the experience of Polish interpreters who translate for mental health professionals: An Interpretative Phenomenological Analysis


Please initial box

1. I confirm that I have read the participant information sheet for the above study, version 2 dated 25/07/2014, and I understand what the study involves.

2. I have had the opportunity to ask questions and have had these answered satisfactorily.

3. I consent to the recording of the interviews and understand that these will be kept confidentially and anonymised.

4. I understand that my participation is voluntary and that I may withdraw from the study at any time, without giving a reason. In this instance I understand that any audio recordings will be erased and not used as part of the research.

5. I understand that research data may be accessed by responsible representatives of the Sponsor (University of Leicester) and the NHS Trusts for the purposes of monitoring / audit.

6. I agree to take part in this research.

_________ ____________ ____________
Name of Participant Date Signature

_________ ____________ ____________
Appendix R: Voucher Receipt form

Voucher Receipt

Research Project Title
Exploring the experience of Polish interpreters who translate for mental health professionals: An Interpretative Phenomenological Analysis

I have received, shopping voucher for £15 in respect of participation in Colm Gallagher’s Doctorate in Clinical Psychology research project as named above.

Name...........................................................................
Signed .....................................................................
Date........................................................................

Appendix S: Example of Initial Analysis

A random piece of transcript was chosen to display an exemplar of the initial coding process. During this interview

This piece was taken from the transcript of Natalia from the first transcript. The interpreter speaks of her passion for her role and feeling rewarded when there are good outcomes for the client, but later in the transcript spoke of being disappointed when they see injustices or when her skills are not utilised.
Interview 1a

NC: Because people have to trust you obviously, because you pass important information from patient to health professionals and the way back, so obviously those people want the person, who, at least, mmm, maybe look the way they are expecting, they know you because they see you more than one time.

LG: Yeah.

NC: They start trusting you and I see, sometimes, people change, like health professionals when they see you more than one time.

LG: Um-hum.

NC: And for the first time, because every time we go in we have evaluation form.

LG: Right.

NC: And sometimes they giving you a good mark.

LG: Um-hum.

NC: And the second, third time ‘excellent’, ‘excellent’, because I feel, it’s not because of the way you interpret because you, mmm, you, like, for example, pick one technique and always try and stick to certain rules.

LG: Um-hum.

NC: And you always work the same way, and they obviously...(they) can’t assess what you really interpret.

LG: Um-hum.

NC: But the way they see you with the patient, they, patient is happy, saying for example, ‘can I have the same interpreter for the next time’. So they, aah, it effect on their decision, what else, they put on evaluation form in terms of ‘excellent’, ‘excellent’. I’m happy, the patient is happy, they want see interpreter again.

LG: Yeah.

NC: They trust the interpreter and we achieve what we wanted, so the information, the flow of the information, we know, the patient knows everything about we wanted and on the way back we know what the patient’s expectations are towards the NHC health professionals.

LG: Yeah, cool, you mentioned techniques, mmm and you said that your technique doesn’t change, can you tell me a little bit more about what you mean by technique?

NC: So depends on mmm, where you interpret, some information an mmm like, techniques are very important, why? Because obviously you have to consider the patient for NHC trust who I am working

LG: Yeah
## Appendix T: Chronology of research progress

<table>
<thead>
<tr>
<th>Date</th>
<th>Research Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>April, 2014</td>
<td>Consultation with field and academic supervisor on research proposal</td>
</tr>
<tr>
<td>May, 2014</td>
<td>Peer Review of proposal</td>
</tr>
<tr>
<td>June, 2014</td>
<td>Submission of Ethics form to university</td>
</tr>
<tr>
<td>June, 2014</td>
<td>Ethics Approval Granted</td>
</tr>
<tr>
<td>July, 2014</td>
<td>NHS permission sought from two trusts</td>
</tr>
<tr>
<td>September, 2014</td>
<td>Site 1</td>
</tr>
<tr>
<td></td>
<td>Site 2</td>
</tr>
<tr>
<td>August – September,</td>
<td>NHS Permission granted</td>
</tr>
<tr>
<td>2014</td>
<td></td>
</tr>
<tr>
<td>August – September,</td>
<td>Participant Recruitment in Trusts. Email sent by Interpreting Service Managers</td>
</tr>
<tr>
<td>2014</td>
<td></td>
</tr>
<tr>
<td>August – September,</td>
<td></td>
</tr>
<tr>
<td>2014</td>
<td></td>
</tr>
<tr>
<td>August – September,</td>
<td></td>
</tr>
<tr>
<td>2014</td>
<td></td>
</tr>
<tr>
<td>August – October,</td>
<td></td>
</tr>
<tr>
<td>2014</td>
<td></td>
</tr>
<tr>
<td>October, 2014</td>
<td></td>
</tr>
<tr>
<td>October – December,</td>
<td>Transcribe Interviews</td>
</tr>
<tr>
<td>2014</td>
<td></td>
</tr>
<tr>
<td>February – March,</td>
<td>Complete Literature Review Analysis and first draft</td>
</tr>
<tr>
<td>2015</td>
<td></td>
</tr>
<tr>
<td>October – April, 2015</td>
<td>Analyse Interview Transcripts</td>
</tr>
<tr>
<td>February – May, 2015</td>
<td>Write up period.</td>
</tr>
<tr>
<td></td>
<td>Submission of thesis to University of Leicester.</td>
</tr>
<tr>
<td>July, 2015</td>
<td>Disseminate Findings</td>
</tr>
<tr>
<td>August – September,</td>
<td>Publish Study</td>
</tr>
<tr>
<td>2015</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Process</th>
<th>Repeated for each participant</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>SS</th>
<th>Interpreters in contact with researcher and recruited into project</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Site 1</td>
</tr>
<tr>
<td></td>
<td>Site 2</td>
</tr>
</tbody>
</table>