Title
Psychological Therapy with Pakistani Clients: A Narrative Analysis of Experiences, Roles, and Relationships within the Therapist, Client and Interpreter Triad

Thesis submitted in partial fulfilment for the requirements of the Doctorate in Clinical Psychology
by Shabana Bashir

Department of Psychology
University of Leicester
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Declaration

I confirm that the research reported is my own work and has not been submitted for any other academic award.
Thesis Abstract

Psychological Therapy with Pakistani Clients: A Narrative Analysis of Experiences, Roles, and Relationships within the Therapist, Client and Interpreter Triad.

By Shabana Bashir

Chapter One: Literature Review

Introduction: This qualitative meta-synthesis aimed to explore the experiences of therapists when working with interpreters in psychotherapy.
Method: Three online databases; Psychinfo, Scopus and Web of Knowledge were searched using combinations of the search terms: ‘interpreter*’ OR ‘translator*’ AND ‘psych*’ OR ‘therap*’. Nine studies were identified after an inclusion/exclusion criteria was applied.
Results: Two overarching themes were identified; the impact of interpreters on communication (subthemes: inaccuracy of interpretation, interpreters’ discomfort with the material discussed, interpreters as cultural communicators), and the impact of interpreters on the therapeutic alliance (subthemes: role of the interpreter, formation of bonds).
Conclusion: The findings of this meta-synthesis suggest that the presence of interpreters has significant impact on therapists’ ability to communicate and form a therapeutic alliance with clients. Recommendations made, include more training for therapists in culture and diversity awareness, and greater training for interpreters to increase their clinical understanding and professional knowledge of therapy.

Chapter Two: Research Report

Introduction: The current research project aimed to explore the narratives held in the triad by Pakistani clients, their therapist and the interpreter about their experiences of psychological therapy, the roles they assumed and the relationships that formed.
Method: Six participants, encompassing two triads participated in semi-structured interviews, which were analysed using a narrative voice-centred relational method of analysis.
Results: Two key narrative themes emerged, centred on a Power Narrative and a Culture Narrative.
Conclusion: The narrative experiences of Pakistani clients, their therapists and interpreters show that a collaborative, triadic form of therapy is incredibly complex. In particular, attitudes towards power, control and culture are predominant themes upon which the therapeutic alliance is based and balanced. The findings emphasise the need for each member being clearly aware of their roles and responsibilities within the triad.

Chapter Three: Critical Appraisal

This critical appraisal provided a reflective account of the researcher’s journey throughout the development and undertaking of the research project.
Acknowledgments

I would like to take this opportunity to thank all those wonderful participants without whose cooperation and trust this entire project would have been lifeless. Thank you for your participation in my journey. Your input and the lessons I have learnt through you, have all been priceless.

My sincerest gratitude goes to my supervisor Dr Steve Melluish; thank you for the support and guidance. Your encouragement and words of wisdom proved to be a great motivator and I have learnt so much from you over the past few years.

To my fellow trainees, thank you for all the help, support, motivation, laughs and not to forget sweet treats.

And finally the heart and soul of my journey, my nearest and dearest. My dearest daughter who made the balance of work and motherhood possible. My extremely supportive husband, at times I have stumbled but you have been right there by my side to pick me up, and to remind me why I started this doctorate in the first place. And last, but by no means least, my wonderful family, my dearest parents and siblings. At times of darkness your patience, support and encouragement is what shone the light for me.
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This review has been written in line with the requirements of a DClinPsych thesis at the University of Leicester. It has however been structured in line with the author guidance for the Journal Psychology and Psychotherapy: Theory, Research and Practice (see Appendix A). Changes to referencing style and word count will need to be made prior to submission to the journal.
Therapists’ experiences of working with interpreters in psychotherapy: A meta-synthesis

By Shabana Bashir

Abstract

Introduction: This qualitative meta-synthesis aimed to explore the experiences of therapists when working with interpreters in psychotherapy.

Method: Three online databases; Psychinfo, Scopus and Web of Knowledge were searched using combinations of the search terms: ‘interpreter*’ OR ‘translator*’ AND ‘psych*’ OR ‘therap*’. Nine studies were identified after an inclusion/exclusion criteria was applied.

Results: Two overarching themes were identified; the impact of interpreters on communication (subthemes: inaccuracy of interpretation, interpreters’ discomfort with the material discussed, interpreters as cultural communicators), and the impact of interpreters on the therapeutic alliance (subthemes: role of the interpreter, formation of bonds).

Conclusion: The findings of this meta-synthesis suggest that the presence of interpreters has significant impact on therapists’ ability to communicate and form a therapeutic alliance with clients. Recommendations made, include more training for therapists in culture and diversity awareness, and greater training for interpreters to increase their clinical understanding and professional knowledge of therapy.

Practitioner Points

- Highlights some of the challenges faced by therapists when working with interpreters in psychotherapy.
- Provides recommendations to minimise the challenges and facilitate the therapists in their work.
**Introduction**

An ethnic disparity in mental health care has gained significant attention worldwide (Alegria *et al.*, 2002; Clow *et al.*, 2003; Coker *et al.*, 2009a). Historically mental health service uptake by ethnic minority groups has been low in Western countries (Hillier *et al.*, 1994). Research focusing on this disparity has identified language and cultural differences (Sentell *et al.*, 2007), a lack of trust in mental health professionals, clients’ own beliefs about mental illness and its treatment and an overall lack of familiarity and understanding of mental health services (Raval, 1996; Tribe, 2005) as some of the key factors that prevent ethnic minority groups from utilising mental health care. With a lack of mental health professionals who have sufficient command of more than one language, the use of interpreters will be needed for the foreseeable future especially as the need for mental health care of non-English speakers becomes greater (Boyle *et al.*, 1993; Tribe, 1999).

**Language and Culture**

Effective communication and a shared understanding are seen to be essential to any meaningful therapist-client interaction (Lee, 1997; Raval, 1996). Working therapeutically with clients with whom language is not shared poses great challenges, particularly as mental health clinicians need to elicit meaningful information from clients in order to make a diagnosis or assess and formulate the client’s difficulties (Farooq & Fear, 2003; Raval, 1996). Additionally there may be words or expressions used within a client’s language, which do not easily translate into the language of the therapist, thus making it difficult for clients to effectively convey their emotions or experiences (Tribe, 1999).

According to Kramsch (2003) the difficulties associated with language differences are magnified when the client’s cultural systems or community is also different. Culture is defined as ‘shared history, practices, beliefs and values of a racial, regional or religious group of people’ (d’Ardenne & Mahtani, 1989). Kramsch (2003) states that language is intrinsic to culture in that it is a way of expressing and communicating values, beliefs and shared experiences that commonly reflect the cultural system or community that the
client is from, thus plays an integral role in social functioning and developing a sense of
group identity.

However in attempting to translate language and meaning several studies have reported
problems or ‘errors’ in the account given through the interpreter’s translation. Common
problems with translating are described by Farooq et al. (1997) who report that ‘errors’
made by interpreters include:

- **Omission** (client’s response is partially or completely removed in the
  interpreters translation);
- **Addition** (the interpreter includes information that is not directly expressed by
  the client);
- **Condensation** (complex or lengthy responses given by the client are simplified,
  therefore key information may be lost in the translation);
- **Substitution** (words or concept described by the client are substituted with
  another word or concept thus leading to inaccurate translation);
- **Role exchange** (where the interpreter completely takes over the interview and
  totally replaces any questions asked by the healthcare professional with their
  own);
- **Closed/open questioning** (the frame of questioning is changed);
- **Normalisation** (where the interpreter attempts to make their own sense of the
  client’s difficulties, thus losing sight of the purpose of the interview).

It is therefore evident from the above that the interpreter exercises a great deal of
control over the direction, tone, and overall effectiveness of any interview process and
therefore can greatly impact the level of care that the client eventually receives from the
therapist (Lee, 1997; Tribe, 1999).

Numerous quantitative studies have focused on the impact that interpreter mediated
communication can have on clinical outcomes (Brune et al., 2014; d’Ardenne et al.,
2007; Renner, 2007; Shulz et al., 2006). Lindholm et al. (2012) compared clinical
outcomes for a group of clients with limited English proficiency who had received
assistance from an interpreter at admission to hospital compared to those that had not.
Patients with access to an interpreter had a decreased length of stay in hospital and were less likely to be readmitted.

Similarly, positive outcomes were demonstrated by Renner (2007) when evaluating the effectiveness of conducting psychotherapy with a group of asylum seekers and refugees with the aid of an interpreter. The Questionnaire of Change in Experience was administered at the beginning and end of therapy, through which it was evident that participants still showed a positive effect, with 85% reporting a significant improvement in their symptoms. D’Ardenne et al. (2007) also evaluated clinical outcomes of psychological therapy. A refugee client group receiving Cognitive Behaviour Therapy (CBT) with the aid of an interpreter was compared with two control groups; refugees who did not require an interpreter and a non-refugee English speaking group. A number of psychological measures were administered pre and post therapy and showed all participant groups required a similar number of sessions and showed a significant improvement following treatment regardless of whether an interpreter was used. Similar positive outcomes have been found in studies by Brune et al. (2011), Van der Rijken et al. (2016) and Shulz (2006), when comparing the effectiveness of psychological treatment with the aid of an interpreter with a matched group that was unaided.

Whilst the presence of an interpreter has been shown to have a positive impact, it is important to acknowledge that some quantitative research has shown that language discordance between client and therapist can negatively impact the assessment and diagnosis of mental health difficulties. One particular study by Stuart et al. (1997) explored the relationship with language and limited English proficiency and the utilisation of mental health services. Results from a survey of clinical staff across a number of mental health settings found that clients who experienced difficulties speaking English were more likely to receive a positive diagnosis of dementia or psychosis. These clients were also less likely to access specialist mental health services, or receive psychotherapy, compared to English speaking clients.
The role of the interpreter

According to Tribe and Morrissey (2004), there are four different roles or ‘modes of interpreting’ used by interpreters: In the ‘linguistic mode’ the interpreter attempts to be neutral and provide a direct, word-for-word translation. In the ‘psychotherapeutic or constructionist mode’ the interpreter attempts to convey the meanings and emotions associated with the material. In the ‘advocate or community interpreter mode’ the role goes beyond just interpreting language and extends to representation of the client or community generally. Finally, in the ‘cultural broker/bicultural worker mode’ the role of the interpreter is to interpret language and also ‘cultural and contextual variables’ associated with it.

Despite these defined roles, clinicians also form their own expectations of what the interpreter’s role should be. According to Lee (1997) there are three types of roles that clinicians can assign to an interpreter: The interpreter as a ‘robot’ or ‘voice machine’ is a role that expects the interpreter to transmit the words ‘verbatim’ from one language to another dispassionately without trying to add any further input or context. The interpreter as a clinician is a role where the therapist looks to the interpreter to make clinical judgements and take part in conducting the therapy due to their increased cultural awareness and knowledge of dealing with issues specific to the patient’s background. Finally, the interpreter as a ‘team partner’ is a balance between the first two; the clinician and interpreter form a partnership where each can play to their strengths – the therapist providing clinical expertise and the interpreter providing linguistic and cultural input.

However, Tribe and Morrissey (2004) stress the importance of discussion between the therapist and interpreter regarding their roles and expectations in order to be clear and create a stable working relationship that is professional and beneficial to the client.

Therapeutic Alliance and the client-therapist dyad

The presence of an interpreter challenges the traditional notion of a therapist-client dyadic relationship (Tribe and Morrissey, 2004), altering the dynamics and ultimately
creating a three-person triadic relationship. According to Lee (1997) ‘what develops is a
triangle with three sets of pairs, or dyads, each one operative at a given point in time’,
as demonstrated in Figure 1.

![Figure 1. Relationship between Provider, Interpreter and Patient (Lee, 1997)](image)

This change in the relationship dynamics from a two-way dyad to a three-way alliance
has been shown to both foster and hamper the concept of therapeutic alliance.
Therapeutic alliance is defined as ‘an agreement on goals, an assignment of tasks or a
series of tasks, and the development of bonds and active collaboration between patient
and therapist’ (Mirdal et al., 2012)

As interpreters are likely to be from a familiar community to the client, their presence
may enhance a sense of trust and fosters a feeling of shared understanding (Tribe,
1999). However the presence of an interpreter may also hinder the therapeutic alliance
as clients may feel a sense of fear or threat that confidentiality may not be upheld due to
a shared cultural and geographical background, thus inhibiting client disclosure and
response (Gerrish et al., 2004).

**Rationale and Aims**

It is evident from the limited amount of research in this area that the presence of an
interpreter can have both a positive and negative impact on the therapeutic process
(Gerrish et al., 2004; Tribe, 1999). Much of this literature has focused on the impact of
using interpreters, but very little has dealt with the qualitative experiences of those
involved. Where this has been done, the existing literature in the area has focused mainly on the perspective of the interpreter and the role that they play. The therapist’s perspective, in particular, appeared to be missing or under-researched.

Existing systematic literature reviews have focused on a mixture of qualitative and quantitative studies to examine the impact and use of interpreters across a range of different health care settings (Brisset et al., 2013; Farooq et al., 2015; Flores, 2005; Karliner et al., 2007; Paone & Malott, 2008; Searight & Armock, 2013; Sleptsova et al., 2014). However, given the impact of interpreters on the therapeutic process, the qualitative literature pertaining to psychotherapies is limited. The most relevant example of a literature review of the use of interpreters in a therapy context was conducted by Paone and Malott (2008) across a counselling setting. The review found that interpreters were able to bridge gaps between the client and the therapist, not only linguistically but also culturally. However, the review mainly focused on the role of the interpreter rather than experiences per se.

It is therefore necessary to explore the experiences of those involved in the therapeutic alliance, particularly the therapist’s experience which is not clearly highlighted in existing reviews. Therefore the aim of the current review is to add to the existing literature by providing a qualitative in-depth exploration of how therapists experience the process of psychotherapy using an interpreter.

**Method**

**Data sources**

To identify qualitative papers for the current review, a systematic search of the existing literature looking at the use of interpreters in psychotherapy was conducted using a number of online databases; Psychinfo, Scopus and Web of Science. Databases were selected to ensure a wide depth of psychological and scientific literature was included. The search was conducted during June 2015 and updated in August 2015.
Search terms

Databases were searched using combinations of the search terms: ‘interpreter*’ OR ‘translator*’ AND ‘psycho*’ OR ‘therap*’. These search terms were grouped to cover the key focus areas in the meta-synthesis including the use of interpreters (interpret* OR translator*) in a psychotherapy context (psych* OR therap*). As shown in Figure 2, these search terms yielded a total of 987 articles after duplicates were removed (greater detail available in Appendix B). Titles and abstracts of the identified articles were scrutinised to assess suitability of the studies. Referencing sections of relevant articles were manually searched to ensure all relevant articles were identified. A total of nine articles met the inclusion/exclusion criteria and included in the synthesis.

Figure 2. Data filtering process
**Inclusion/exclusion criteria**

Papers were only included in the meta-synthesis if (a) interpreters were utilised to aid communication, (b) they were peer-reviewed, (c) they were written in the English language, (d) they employed a qualitative methodology to explore the therapists’ experiences of working with interpreters (studies that also explored the experiences of clients and interpreters were still included if it was possible to separate out therapists’ experiences and perspectives from the clients and interpreters). Papers were considered to be qualitative if they utilised qualitative data collection methods, such as semi-structured interviews or where data collected was analysed qualitatively, for example using thematic analysis (Sandelowski & Barroso, 2007).

Due to limited research in this area the searches were not restricted to a particular date range as it was felt that this would reduce the scope and depth of the current review.

Papers were excluded if (a) they were reviews, case studies, general discursive articles or book chapters, and (b) they did not specifically relate to the area of this meta-synthesis.

**Quality assessment**

The ten papers identified from the search were assessed for quality and methodological rigour using the Critical Appraisal Skills Programme (CASP). The CASP appraisal of studies can be found in Table 1. Based on the CASP quality assessment one study was excluded as there was no clear data analysis method described and it did not include quotes in the results or analysis, thus making it difficult to ascertain whether the findings were grounded in the original data. Nine studies were therefore included in the meta-synthesis.
Studies included

All nine studies included in the meta-synthesis shared a broad aim of investigating therapists’ experiences of working with interpreters. A characteristic profile of the nine included studies can be found in Table 2.

Data analysis

A number of different methodological approaches to synthesising qualitative research have emerged over recent years (Barnett-Page & Thomas, 2009). The meta-synthesis used in the current review was based on an interpretative approach proposed by Sandelowski and Borroso (2007). Other widely-used analysis methods such as meta-ethnography (Noblit & Hare, 1988) compare findings of the studies interpretively, whereas the approach used by Sandelowski and Borroso (2007) was chosen as it allowed the researcher to interpretively integrate findings of studies to contribute to a wider picture and develop a more integrative overview of the experiences that therapists have. The stages of synthesis involved:

a) Reading each paper comprehensively;

b) Highlighting key findings of each paper;

c) Mapping the highlighted findings;

d) Collating and organising findings into themes;

e) Revisiting the papers and fine-tuning findings based on insight gained from organising themes, and;

f) Concluding theme titles and descriptions.

A description of the main themes identified in the studies included in the meta-synthesis can be found in Table 3. A table of how these themes were translated through the meta-synthesis can be found in Table 4.
Table 1: CASP quality appraisal of articles

<table>
<thead>
<tr>
<th>Paper</th>
<th>Clear statement of aims</th>
<th>Appropriate methodology</th>
<th>Appropriate research design</th>
<th>Appropriate research strategy</th>
<th>Appropriate data collection</th>
<th>Researcher-participant relationship considered</th>
<th>Considered ethical issues</th>
<th>Rigorous data analysis</th>
<th>Clear findings</th>
<th>Value of research</th>
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<tbody>
<tr>
<td>Becher &amp; Wissing (2015)</td>
<td>Y</td>
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<td>Engstrom et al. (2010)</td>
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<td>Kamy et al. (2015)</td>
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<td>Leanza et al. (2015)</td>
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<td>Miller et al. (2005)</td>
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<td>Mirdal et al. (2012)</td>
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<td>Pugh &amp; Veturs (2009)</td>
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<td>Raval (1994)</td>
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<td>Raval &amp; Smith (2003)</td>
<td>Y</td>
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<tr>
<td>Paper</td>
<td>Country</td>
<td>Sample details</td>
<td>Recruitment</td>
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<td>Data collection</td>
<td>Data Analysis</td>
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<tr>
<td>Becker &amp; Wieling</td>
<td>USA</td>
<td>7 therapists (3 males, 4 females)</td>
<td>Convenience Sample: Recruited from a range of healthcare settings</td>
<td>Examine the impact of power and privilege on therapists and interpreter relationship.</td>
<td>Semi-structured interviews</td>
<td>Developmental Research Sequence</td>
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<td>(2015)</td>
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<tr>
<td>Engstrom et al.</td>
<td>USA</td>
<td>10 therapists (9 females, 1 male)</td>
<td>Convenience sample: recruited from regional torture treatment centre</td>
<td>Examine how the use of interpreters affects the process of psychotherapy and psychological affidavits documenting the psychological effects of torture</td>
<td>Semi-structured interviews</td>
<td>Content analysis (descriptive)</td>
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<td>(2010)</td>
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<td>Age range: 34 – 74</td>
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<tr>
<td>Kuay et al. (2015)</td>
<td>Australia</td>
<td>10 therapists (8 females, 2 males)</td>
<td>Convenience Sample: Recruited from Victorian Foundation for the survivors of torture.</td>
<td>Explore how clinicians prepare and use interpreters during psychotherapy and how they manage therapy dynamics.</td>
<td>Semi-structured interviews</td>
<td>Grounded theory</td>
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<td>Lomza et al. (2015)</td>
<td>Canada and France</td>
<td>18 therapists (15 females, 3 males)</td>
<td>Convenience Sample: Recruited from two child and adolescent mental health clinics</td>
<td>Explore the integration of interpreters in child and adolescent mental health interventions</td>
<td>Focus groups</td>
<td>Thematic analysis</td>
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<td>Miller et al. (2005)</td>
<td>USA</td>
<td>15 therapists (10 female, 5 male)</td>
<td>Convenience Sample: Recruited from 10 torture treatment centres and 4 refugee mental health clinics</td>
<td>Examine (a) the impact that interpreters may have on the therapy process (b) the complex emotional reactions that arise within the therapy trial</td>
<td>Semi-structured interviews</td>
<td>Thematic analysis - NUD*IST</td>
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<td>Study (Year)</td>
<td>Country</td>
<td>Participants</td>
<td>Sample Description</td>
<td>Research Question</td>
<td>Methodology</td>
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<tr>
<td>Mirdal et al. (2012)</td>
<td>Denmark</td>
<td>4 therapists</td>
<td>Convenience Sample: Recruited from two rehabilitation clinics</td>
<td>Explore how therapists, clients and interpreters experience the therapy process and what they consider to be creative and/or impeding factors</td>
<td>Semi-structured interviews</td>
<td>Qualitative Phenomenological approach</td>
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<tr>
<td>Pugh &amp; Veterso (2009)</td>
<td>UK</td>
<td>10 therapists (7 females, 3 males)</td>
<td>Convenience Sample: Recruited from two mental health services</td>
<td>Explore therapists' experiences of empathy in clinical work with an interpreter</td>
<td>Semi-structured interviews</td>
<td>Interpretative phenomenological analysis</td>
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<tr>
<td>Raval &amp; Smith (2003)</td>
<td>UK</td>
<td>9 therapists (8 females, 1 male) Mean age: 40.5 years</td>
<td>Convenience Sample: Recruited from UK CAAMHS</td>
<td>Understand mental health practitioners' experiences of carrying out therapeutic work with the help of an interpreter</td>
<td>Semi-structured interviews</td>
<td>Interpretative phenomenological analysis</td>
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<tr>
<td>Yakushko (2010)</td>
<td>USA</td>
<td>8 therapists (6 females, 2 males)</td>
<td>Convenience Sample: Recruited from a range of healthcare settings</td>
<td>Examine the experiences of therapists working with clients with limited English proficiency</td>
<td>Semi-structured interviews</td>
<td>Thematic analysis</td>
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</table>
Table 3: Summary of the main findings of the studies included in the meta-synthesis

<table>
<thead>
<tr>
<th>Paper</th>
<th>Meta finding of study</th>
</tr>
</thead>
</table>
| Becker & Weiling (2015)      | Theme 1: Interpreters speaking out  
                                  Theme 2: The relationship matters  
                                  Theme 3: Who has the power?                                                  |
| Augsten et al. (2010)        | Theme 1: Communication  
                                  Subthemes:  
                                  Interpreters as cultural broker  
                                  Inaccurate interpretations  
                                  Interpreters discomfort with material  
                                  Inappropriate client-interpreter match  
                                  Inconsistency  
                                  Theme 2: Clinical Problems  
                                  Subthemes:  
                                  Establishing relationships  
                                  Interpreters complex emotional reactions                                         |
| Kasy et al. (2015)           | Theme 1: Comparison with existing guidelines for interpreter usage  
                                  Subthemes:  
                                  Phone or onsite interpreter  
                                  Briefing  
                                  Gender, religion, cultural matching  
                                  Cultural consultancy  
                                  Theme 2: Specific issues relating to interpreter usage and psychotherapy  
                                  Subthemes:  
                                  Advocacy  
                                  Interpreter empathy  
                                  Troubleshooting empathy issues  
                                  Perceived roles  
                                  Troubleshooting perceived roles  
                                  Therapists debriefing interpreters  
                                  Presence of interpreter facilitates psychotherapeutic work  
                                  Presence of interpreter inhibits psychotherapeutic work                       |
| Lebow et al. (2015)          | Theme 1: the development and the maintenance of a working alliance  
                                  Theme 2: the delineation of interpreters roles  
                                  Theme 3: the effects of translation on people in the interaction               |
<table>
<thead>
<tr>
<th>Author(s) (Year)</th>
<th>Themes</th>
</tr>
</thead>
</table>
| Miller et al. (2005) | Theme 1: Impact on therapeutic alliance  
Theme 2: Therapist reactions  
Theme 3: Interpreter reactions  
Theme 4: The impact of interpreting on interpreters well-being  
Theme 5: The hiring, training and ongoing support of interpreters (and therapists) |
| Mirdal et al. (2012) | Theme 1: Curative factors  
Theme 2: Impeding factors |
| Pugh & Vetere (2009) | Theme 1: The effects of translation upon the quality of empathic dialogues with clients  
Theme 2: Changes in empathic communication and the difficulty evaluating clients empathic reception  
Theme 3: The interpreters mediation of empathic communication with the client  
Theme 4: The difficulty of evaluating the clients reception of professionals empathy  
Theme 5: Cultural issues arising within the client- interpreter dyad  
Theme 6: Cultural issues arising within the client- interpreter dyad  
Theme 7: Opportunities for the interpreter to enrich the professional understanding of the client |
| Raval & Smith (2003) | Theme 1: The process of communication through translation  
Subthemes:  
Communication and language  
The translation process  
Theme 2: The impact of translation on the therapeutic style  
Subthemes:  
Changes in style of questioning  
Theme 3: The intervention becomes simplified  
Theme 4: The difficulty of establishing a co-worker alliance  
Subthemes:  
The worker alliance is not the same as that between two therapists  
Power differentials  
Role of ambiguity and disempowerment  
Trust  
Long term therapeutic alliances were difficult to establish with families |
| Yakoshko (2010) | Theme 1: Personality and training of therapist  
Theme 2: Personality and training of interpreter |
Table 4: Themes identified in the meta-synthesis (including translation of the original study themes)

<table>
<thead>
<tr>
<th>Paper</th>
<th>The impact of interpreters on communication</th>
<th>The impact of interpreters on therapeutic alliance</th>
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<tbody>
<tr>
<td></td>
<td>The inaccuracy of interpretation</td>
<td>The role of the interpreter</td>
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<td></td>
<td>Interpreters' discomfort</td>
<td>The formation of bonds</td>
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<td></td>
<td>Interpreters as cultural communicators</td>
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<tr>
<td>Becher &amp; Wieling (2015)</td>
<td>X</td>
<td>Interpreters speaking out</td>
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<td>The relationship matters</td>
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<td>Who has the power?</td>
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<td>Bangstrom et al. (2016)</td>
<td>Inaccurate interpretations</td>
<td>Inconsistency</td>
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<td>Interpreters discomfort</td>
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<td>Interpreters complex</td>
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<td>emotional reactions</td>
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<td>Kuty et al. (2015)</td>
<td>Cultural consultancy</td>
<td>Gender, religion, cultural matching</td>
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<td></td>
<td>X</td>
<td>Cultural consultancy</td>
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<td>Presence of interpreter</td>
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<td>Facilitates psychotherapeutic work</td>
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<td>Leanza et al. (2015)</td>
<td>The development and the maintenance of a working alliance</td>
<td>The delineation of interpreters roles</td>
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<td>The development and the maintenance of a working alliance</td>
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<td>The effects of translation on people in the interaction</td>
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<td>Miller et al. (2005)</td>
<td>Therapist reactions</td>
<td>Impact on therapeutic alliance</td>
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<td>Interpreter reactions</td>
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<td>Mindal et al. (2012)</td>
<td>Impeding factors</td>
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<td>Impeding factors</td>
<td>Curative factors</td>
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<td>Authors (Year)</td>
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<td>Pugh &amp; Vetere (2009)</td>
<td>The effects of translation upon the quality of empathic dialogues with clients</td>
<td>Cultural issues arising within the client-interpretor dyad</td>
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<td>Changes in empathic communication and the difficulty evaluating clients empathic reception</td>
<td>Opportunities for the interpreter to enrich the professional understanding of the client</td>
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<td>The difficulty of evaluating the clients reception of professionals empathy</td>
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<td>Raval &amp; Smith (2003)</td>
<td>The translation process</td>
<td>The impact of translation on the therapeutic style</td>
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<td>The intervention becomes simplified</td>
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<td>The worker alliance is not the same as that between two therapists</td>
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<td>The worker alliance is not the same as that between two therapists</td>
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<td>Yakushko (2010)</td>
<td>X</td>
<td>Personality and training of interpreter</td>
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<td>Personality and training of interpreter</td>
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Results

The meta-synthesis identified two overarching themes relating to how therapists experience the process of working therapeutically with an interpreter. These are: the impact of interpreters on communication, and the impact of interpreters on the therapeutic alliance. All quotes are direct therapist quotations obtained from the primary data source.

The impact of interpreters on communication

The overarching theme of communication through interpreters encapsulated the following sub-themes: inaccuracy of interpretation, interpreters’ discomfort with the material discussed, and interpreters as cultural communicators.

Inaccuracy of interpretation

This theme related to how therapists felt interpreters influenced the process of communication and was discussed in eight papers (Becher & Wieling, 2015; Engstrom et al., 2010; Kuay et al., 2015; Leanza et al., 2015; Miller et al., 2005; Mirdal et al., 2012; Pugh & Vetere, 2009; Raval & Smith, 2003).

Many therapists spoke about their concern of key aspects of the communication being lost to them through translation (Becher & Wieling, 2015; Engstrom et al., 2010; Kuay et al., 2015; Leanza et al., 2015; Miller et al., 2005; Mirdal et al., 2012; Pugh & Vetere, 2009; Raval & Smith, 2003).

“I think working with interpreters, one’s never quite sure of what one’s missing, so it’s quite difficult I think to have dialogues.” (Raval & Smith, 2003, p.12).

There was an inherent concern over what the therapists felt was the interpreter’s decision to translate selectively, by omitting aspects of the conversation (Engstrom et al., 2010; Miller et al., 2005; Mirdal et al., 2012; Pugh & Vetere, 2009; Raval & Smith,
The ‘frustration’ that this caused therapists is illustrated in the following excerpt from the Miller et al. (2005) study:

"She would choose not to say certain things that she did not herself want to deal with, or she would make commentary on what other people were saying. . . . That was a really frustrating experience.” (p.33).

Therapists also reported other issues with interpreters’ translations, that of translating too concretely or watering down the translation, which many therapists felt undermined the accuracy of the translation (Engstrom et al., 2010; Miller et al., 2005; Mirdal et al., 2012; Pugh & Vetere, 2009; Raval & Smith, 2003). The following excerpt taken from Engstrom et al. (2010) illustrates the frustration that this causes:

“The gal sanitized it completely. She said, “Well, he saw terrible things.” That was not adequate. And I knew she’d sanitized it because I recognized enough from the Spanish. . . . But what came to me was vanilla and what he had explained was splattered with blood, you know. So it was one of those distressing things for me that I couldn’t get an accurate explanation” (p.64)

Many therapists felt that interpreters often incorporated their own assumptions or interpretations of what they felt the therapist or client were trying to convey: “The interpreter may hear things that they have their own assumptions about, so they might use their own interpretations about what a client has said”(Pugh & Vetere, 2009, p.313), resulting in an inherent tension amongst therapists with having to work with summarised information from the interpreter (Engstrom et al., 2010; Mirdal et al., 2012 & Raval & Smith, 2003). This tension is explained by a therapist in the Raval and Smith (2003) study:

“It’s like getting a précis, instead of reading, watching, and understanding a three and a half hour version of King Lear, you’re getting a three line précis of the King goes mad and his daughters give him a hard time” (p.11)
Having “prior information about the client which contradicted the client’s narratives during therapy” fuelled the anxiety experienced by therapists in the Mirdal et al. (2012, p.454) study. This feeling of the therapist meeting a completely different client to the one they were expecting based on prior research of the client’s notes was attributed to inaccurate interpretation and translation (Mirdal et al., 2012).

Therapists across four of the studies expressed concern that even small changes made by the interpreters could lead to significant changes to the meaning of what the therapist or client was trying to convey (Engstrom et al., 2010; Mirdal et al., 2012; Pugh & Vetere, 2009; Raval & Smith, 2003).

“I think, sometimes, um, what you’re trying to say doesn’t always get put through as effectively as you’d like ...And often what’s coming back I don’t think fully reflects what the client is saying” (Pugh & Vetere, 2009, p.313).

Not being able to get feedback from clients regarding the accuracy of the translation exacerbated this concern for some therapists (Pugh & Vetere, 2009; Raval & Smith, 2003).

“There’s no way that you can actually check back that what the family is being asked is actually what you asked through the interpreter” (Raval & Smith 2003, p.12).

Whilst most spoke about disadvantages of inaccuracies, therapists in the Leanza et al., 2015 study took a positive take on this:

“I think that interpretation accuracy does not lie within word for word, because it can take a long time to explain something to the family and we have an answer of a few words. We should not always worry about it in the sense that often, something of the context had to be explained.” (p.363)
Interpreters’ discomfort with the material discussed

Interpreter discomfort was mentioned in seven papers (Engstrom et al., 2010; Leanza et al., 2015; Miller et al., 2005; Mirdal et al., 2012; Pugh & Vetere, 2009; Raval & Smith, 2003; Yakushko, 2010). Interpreter discomfort was seen to affect communication drastically, as certain themes could be omitted or ignored dependent on the interpreter’s willingness to repeat back more raw or graphic communications, particularly if they felt uncomfortable or found the material hard to repeat (Engstrom et al., 2010; Leanza et al., 2015; Miller et al., 2005; Pugh & Vetere, 2009; Raval & Smith, 2003).

“I think they may change it more to be what they are. Minimizing or softening some things may be out of their own concern of even saying things.” (Engstrom et al., 2010, p.65).

The interpreter’s cultural background and their social or political views may explain the discomfort they felt with some of the material reported by the client or discussed by the therapist. These cultural barriers could have led to omission of important material with a view to not offending either the client or the therapist (Engstrom et al., 2010, Pugh & Vetere, 2009).

“Sometimes you don’t know. What they may be doing is sort of smoothing over cultural disconnects or things that might be offensive or whatever in the translation. I guess you kind of hope they’re not doing that, you hope that they aren’t losing the meaning that you’re trying to get at.” (Engstrom et al., 2010, p.65).

Conversely, some therapists in one of the studies felt that cultural barriers could equally be attributed to causing offence if the interpreter was not culturally sensitive enough to fully understand the client therefore offending the client with the wording of certain questions (Pugh & Vetere, 2009).

“[The client] obviously had an issue with the fact that, the person who was interpreting was not from their sector of the community...There was a big sense
of, kind of, ‘Why are asking me this question in that kind of way?’, from the person who was being asked the question” (Pugh & Vetere, 2009, p.311).

There is also a wider implication of the interpreter becoming personally distressed by what they are hearing and transmitting and this begins to affect the quality of their translations and the extent or detail in which they are able to communicate the translated material (Engstrom et al., 2010; Leanza et al., 2015; Miller et al., 2005; Mirdal et al., 2012; Pugh & Vetere, 2009; Raval & Smith, 2003; Yakushko, 2010).

“I have had experiences where [interpreters] were defending the client . . . They were translating what was said, but with their whole body language, it was like they were there to “protect” the client. They perceived [my] questions as an attack [to the patient and his/her family].” (Leanza et al., 2015, p.361)

Emotional reactions from the interpreters themselves over the course of the therapy gradually degrade the quality of interpretation and have been mentioned as a barrier to communication in several studies (Engstrom et al., 2010; Miller et al., 2005; Mirdal et al., 2012).

“I think that (. .) things that are difficult to say (. . .) or ask, questions that are difficult to ask of a family (. . .) well it’s what I was saying earlier, you get to the point of asking them because you’ve done quite a lot of internal work yourself but the interpreter hasn’t done that internal work and that doesn’t mean that the interpreter doesn’t need to do that internal work before they can feel comfortable with asking that question.” (Raval & Smith, 2003, p.14-15).

**Interpreters as cultural communicators**

Although interpreters were seen to negatively affect communication between the client and therapist, a key advantage of working with interpreters reported across all nine studies was that the interpreter could act as a “cultural broker” (Becher & Wieling, 2015, p.453; Engstrom et al., 2010, p.63) who could help therapists communicate by
gaining a better understanding of the client’s culture, cultural beliefs and cultural systems (Becher & Wieling, 2015; Engstrom et al., 2010; Kuay et al., 2015; Leanza et al., 2015; Miller et al., 2005; Pugh & Vetere, 2009; Raval & Smith, 2003; Yakushko, 2010).

“Because she’s Kurdish she knows a lot about the culture and how to relate to these clients. So I actually ended up learning a lot from her as far as learning how to relate to them. I think in many ways besides being an interpreter she was a cultural broker, absolutely. She really gave me a lot of clues about how to interpret lots of things, verbal and nonverbal, that I had no clue. I was at a total loss. She was great. I developed a great relationship with her. I learned a lot from her and I love working with her. She was totally a cultural broker.” (Engstrom et al., 2010, p.63).

Other words used to describe this role of the interpreter include “cultural consultant” (Miller et al., 2010, p.30) and “cultural advisor” (Raval & Smith, 2003, p.20), and there is a general theme across the studies that communication is enhanced by the interpreter’s perspective and enables the therapist to gain insight into the client’s background which could not otherwise be fully understood (Becher & Wieling, 2015; Engstrom et al., 2010; Kuay et al., 2015; Leanza et al., 2015; Miller et al., 2005; Pugh & Vetere, 2009; Raval & Smith, 2003; Yakushko, 2010).

“The family has a different culture and there may be a feeling of strangeness. Sometimes you feel less isolated when the interpreter is there . . . . Even if the family speaks English or French, there is a certain cultural distance; a bridge is built thanks to the interpreter.” (Leanza et al., 2015, p366)

Although most therapists valued the contributions of the interpreter in gaining an understanding and making sense of the client’s culture and experiences (Becher & Wieling, 2015; Engstrom et al., 2010; Kuay et al., 2015; Leanza et al., 2015; Miller et al., 2005; Pugh & Vetere, 2009; Raval & Smith, 2003; Yakushko, 2010), cultural issues between client and interpreter sometimes made communication harder. These problems could be in the form of cultural differences if, for example, clients and interpreters from
the same country shared totally different cultures based on their affiliation to different
groups within that country (Pugh & Vetere, 2009; Yakushko, 2010) or if there were
religious differences (Kuay et al., 2015).

“They may speak the same language but not the same culture,” (Yakushko, 2010, p.452).

“…the lady was wearing a hijab – a headscarf – and that client did address
later on that it was something that she [Christian patient] didn’t feel
comfortable with…” (Kuay et al., 2015, p. 284)

However, communication could be just as easily affected by cultural similarity between
the client and interpreter as the client could feel embarrassed or stigmatised by the
interpreter’s reactions or perceived judging of the client based on shared cultural
misconceptions (Pugh & Vetere, 2009).

“It’s a small world… Having distress and not handling things as you would like
is, can be very stigmatizing”. (Pugh & Vetere, 2009, p.311).

The impact of interpreters on therapeutic alliance

The overarching theme of the impact of interpreters on the therapeutic alliance
included: the role of the interpreter, and the formation of bonds.

The role of the interpreter

When talking about the therapeutic alliance, most therapists specified their expectations
of the role of the interpreter and this was a recurring theme that was discussed across all
nine studies. Most therapists saw the role of the interpreter as a member of their team
who together with the client forms a therapeutic alliance (Becher & Wieling, 2015;
Engstrom et al., 2010; Kuay et al., 2015; Miller et al., 2005; Mirdal et al., 2012; Pugh
& Vetere, 2009; Raval & Smith, 2003; Yakushko, 2010). Therefore the interpreter is
seen as a key member of the partnership and in some cases almost as a co-therapist due to the significant contribution they can make to the alliance through the power of communication and first-hand understanding.

“Whereas my experience here has been very different because the interpreter has seen himself as an integral part of the team and it wasn’t like working through a third person, it was like working with a co-therapist.” (Raval & Smith, 2003, p.18).

“Interpreters are not a mouthpiece but are central to all aspect of the work.” (Yakushko, 2010, p.452).

However some therapists are also reluctant due to professional barriers or feelings of awkwardness to consult interpreters on many aspects of the therapy and fully commit to a co-therapist role for the interpreter (Engstrom et al., 2010, Leanza et al., 2015; Raval & Smith, 2003).

“[I]t’s a whole new dynamic with a third person there . . . the practitioner needs to convey a sense that they trust the interpreter. . . . One needs to convey to the client also that you understand why they would be worried.” (Engstrom et al., 2010, p.68).

In many cases the intimate involvement of the interpreter exceeded or overstepped the role that was envisaged by the therapist and created its own problems when it came to relating to the client or focussing on the client’s issues. (Becher & Wieling, 2015; Engstrom et al., 2010; Kuay et al. 2015; Miller et al., 2005; Raval & Smith, 2003).

“There [were] a few times when I was working with an interpreter and I was asking about a particularly sensitive topic, and the interpreter stopped me and said, “Please don’t ask her about that, that is going too far, you are going too deep, she is not ready for that,” and I said essentially, “Well you are going to have to trust me as the therapist here that I will handle this in a delicate way, but I think it is important that we take this to the next level.” And I had to
convince the interpreter to actually do what I thought was therapeutically indicated.” (Miller et al., 2005, p.33).

This leads to a certain amount of confusion or dilemma for the therapist as to how useful it is to involve the interpreter in aspects of the therapeutic alliance and to what extent their role is a partnership.

“Because I think issues for me are how much do you kind of let the interpreter get on with it and use their own ideas, almost kind of work as a co-therapist, and how much do you strictly use them kind of as a person who translates.” (Raval & Smith, 2003, p.17).

Feelings of comfort or familiarity between the therapist and interpreter are key to the success of the therapeutic alliance. Where trust has been built up and formed between a therapist and an interpreter it is easier to define and understand mutual roles. It can be unsettling for the therapeutic alliance if this balance is spoiled by practical issues such as having to use different interpreters and lacking the consistency of being able to use a regular interpreter (Becher & Wieling, 2015; Engstrom et al., 2010; Leanza et al., 2015; Mirdal et al., 2012; Miller et al., 2005; Raval & Smith, 2003; Yakushko, 2010).

“Having an interpreter who is also a cotherapist, it is a comfort! We can then be more subtle in our work. But when we have an interpreter with whom we are not familiar, we try to be much more simple and clear.” (Leanza et al., 2015, p.365)

As mentioned above the majority of therapists worked towards building a partnership with their interpreter, however it is important to highlight the different perspective of some therapists in the Miller et al. (2005) and Kuay et al. (2015) studies who reported seeing the role of the interpreter as a mere translating “machine” (Miller et al., 2005, p.29) whose relationship with the client was not seen to be very significant to the therapeutic alliance. Instead the focus for these therapists remained to develop the traditional therapist-client dyadic relationship.
Similarly a few therapists in the Raval and Smith (2003) study reported that inherent status differences within their workplace structure made it difficult to establish a co-therapist alliance.

“I do think of the interpreter as a co-worker. Now there are problems about that because she isn’t. She isn’t, that’s not recognized in the (...) status and salary and all those sorts of things so, and that creates problems” (Raval and Smith, 2003, p.18).

The formation of bonds

All six studies mention the formation of bonds as a key aspect of the therapeutic alliance (Engstrom et al., 2010; Miller et al., 2005; Mirdal et al., 2012; Pugh & Vetere, 2009; Raval & Smith, 2003; Yakushko, 2010). Despite the different roles allocated and importance given by therapists to interpreters, it was evident from several studies that this view was not shared by clients, who most therapists felt formed stronger bonds or alliances with the interpreter (Becher & Wieling, 2015; Engstrom et al., 2010; Leanza et al., 2015; Miller et al., 2005; Pugh & Vetere, 2009; Raval & Smith, 2003).

“It does feel that the connection is set up I think quite quickly between the interpreter and the client, perhaps because that’s where the conversation is happening” (Pugh & Vetere, 2009, p.310).

Some therapists spoke about feeling like a strong therapeutic alliance had been formed between the client and interpreter and reported almost feeling left out or “frustrated” (Becher & Wieling, 2015, p454).

“Yes I wonder about that, I wonder if the therapist is not often perceived as the spare part because (laughs) the interpreter actually makes a really strong link with the family” (Raval & Smith, 2003, p.21).

Therapists in the Kuay et al. (2015) study spoke about ways of managing this:
“…I sit with it and if it gets too long, then I’ll say, ‘Excuse me, can I be part of this?’ …and then the interpreter laughs and then they kind of realise…” (p285)

However the formation of bonds is dependent on the relationship and dynamic of the therapeutic alliance, and can involve all three parties mutually.

“There was a kind of primitive bond among us. A bond between three women”
(Mirdal et al., 2012, p.449).

This kind of bonding helps the client to establish trust and gain confidence that their words are being translated and transmitted faithfully and accurately to the therapist, and that the interpreter is able to transmit the material sympathetically.

“This therapy is always a team project. It’s hard to imagine this work in any other way. You have to trust the interpreter. [The] client has to trust the interpreter. Being from another culture, you must have a partnership with your interpreter. In fact, you must follow their [interpreters’] lead about cultural rules and also explaining cultural nuances.” (Yakushko, 2010, p.451).

There are however challenges and issues with the formation of bonds between the client and the interpreter, as Engstrom et al. (2010) reported that mental health workers reported concern that therapeutic relationships appeared to be developing between the client and interpreter, which is complicated when the work has a therapeutic focus. Mirdal et al. (2012), also mention that client-interpreter bonds can become too deep and result in a lack of professionalism that is not conducive to the therapeutic alliance.

“I have had the feeling that they [the interpreter and the patient] met privately”
(Mirdal et al., p.453).
Discussion

This meta-synthesis brings together the findings of qualitative studies looking at therapists’ experiences of working with interpreters in psychotherapy. Nine studies were included for synthesis in the current review. The overall quality of the studies was assessed using the CASP. On the whole, according to the CASP all the studies showed good quality indicators. The only category in which the majority of studies lacked consideration was the researcher-participant relationship. Overall, it was concluded that the studies were of comparable quality and considered relevant to be included in the review.

From reviewing the literature and synthesising the findings it is evident that the presence of interpreters has significant impact on the therapists’ ability to communicate and form a therapeutic alliance with clients (Becher & Wieling, 2015; Engstrom et al., 2010; Kuay et al., 2015; Leanza et al., 2015; Miller et al., 2005; Mirdal et al., 2012; Pugh & Vetere, 2009; Raval & Smith, 2003; Yakushko, 2010).

Therapists described concern over the decision of the interpreter to omit or change things (Becher & Wieling, 2015; Engstrom et al., 2010; Kuay et al., 2015; Leanza et al., 2015; Miller et al., 2005; Mirdal et al., 2012; Pugh & Vetere, 2009; Raval & Smith, 2003). Inaccuracy of interpretation was a significant concern to therapists and led to a breakdown in communication with the client (Engstrom et al., 2010; Miller et al., 2005; Mirdal et al., 2012; Pugh & Vetere, 2009; Raval & Smith, 2003). There were several reasons why interpreters may have chosen to omit or change material: discomfort regarding the content of what was being talked about (Engstrom et al., 2010; Leanza et al., 2015; Miller et al., 2005; Mirdal et al., 2012; Pugh & Vetere, 2009; Raval & Smith, 2003), embarrassment or worry that translating certain remarks would be offensive (Engstrom et al., 2010; Leanza et al., 2015; Pugh & Vetere, 2009;), feelings of emotion and distress (Engstrom et al., 2010; Miller et al., 2005; Mirdal et al., 2012), lack of cultural empathy with the client (Pugh & Vetere, 2009; Yakushko, 2010) and over-familiarity and unprofessionalism (Engstrom et al., 2010; Mirdal et al., 2012).
Despite this, therapists spoke about how the interpreter helped bridge the cultural gap and understand the client’s culture, working as a ‘cultural broker’ (Becher & Wieling, 2015; Engstrom et al., 2010; Leanza et al., 2015; Miller et al., 2005; Pugh & Vetere, 2009; Raval & Smith, 2003; Yakushko, 2010). This is important as both Lee (1997) and Raval (1996) report that developing a shared understanding is essential to any meaningful therapist-client interaction.

Cultural understanding could help to form bonds and establish trust between the interpreter and client (Becher & Wieling, 2015; Engstrom et al., 2010; Kuay et al., 2015; Leanza et al., 2015; Miller et al., 2005; Pugh & Vetere, 2009; Raval & Smith, 2003). In most cases this was seen as helpful and useful for the therapist to form a better relationship with the client, with the interpreter as a facilitator (Becher & Wieling, 2015; Engstrom et al., 2010; Leanza et al., 2015; Miller et al., 2005; Pugh & Vetere, 2009; Raval & Smith, 2003; Yakushko, 2010). Where this was seen to break down was when the balance was tipped too far and the interpreter took over or was seen to replace the therapist due to the familiarity developed with the client (Engstrom et al., 2010; Leanza et al., 2015; Mirdal et al., 2012). Although this was useful to an extent, therapists felt that on a professional level familiarity based on language and culture was not more important than the therapeutic relationship between therapist and client (Miller et al., 2005; Raval & Smith, 2003).

Interpreters were seen to play several different roles in the therapeutic relationship. Some therapists saw them as a translating machine whereas others saw them as a fundamental aspect of the relationship and members of a three-person alliance. The term ‘co-therapist’ was used by some therapists to try to explain the extent to which they relied on their interpreters not just as word-for-word translators but to deliver a rich communication with the client (Raval & Smith, 2003).

Overall therapists saw the role of the interpreter as going beyond translating. Interpreters provided an insight into the client’s language, culture and experiences (Becher & Wieling, 2015; Engstrom et al., 2010; Kuay et al., 2015; Leanza et al., 2015; Miller et al., 2005; Mirdal et al., 2012; Pugh & Vetere, 2009; Raval & Smith, 2003; Yakushko, 2010).
Although some therapists expressed a desire for interpreters to be in the background, clients themselves did not share this view. This was evidenced by therapists reporting an initial stronger bond between client and interpreter (Becher & Wieling, 2015; Engstrom et al., 2010; Leanza et al., 2015; Miller et al., 2005; Pugh & Vetere, 2009; Raval & Smith, 2003).

Therapists acknowledged that due to the integral role played by interpreters and the bonds that are developed with clients, they needed to work on developing a strong relationship with the interpreter themselves (Mirdal et al., 2012; Yakushko, 2010). This included building up their own professional working relationship with a particular set of personnel and having a consistent working partnership that did not change (Mirdal et al., 2012; Miller et al., 2005; Raval & Smith, 2003; Yakushko, 2010).

These findings have significant ethical, professional and clinical implications on practice. The use of interpreters clearly introduces another variable into a client’s treatment, and this could result in inequality of service for clients with language barriers. The extra time constraints introduced by translation and repetition, together with the inconsistency of interpreters used could disadvantage the client and result in poor quality of care. Interpreters themselves may not be subject to the same professional standards as trained healthcare professionals and clients could be reluctant or mistrustful when divulging important details relating to their experiences. The fact that information needs to be relayed to a go-between always leaves the risk of creating a lot of scope for inconsistency, mistranslation, personal interpretation, second-hand communication, and unprofessionalism.

The alliance between therapist and interpreter can be seen as an alliance of convenience where the only need for the interpreter’s presence is the fact that the therapist does not have command of the client’s language or knowledge of the client’s culture. This entire system could be rationalised in the long term by stressing a need to train more therapists in culture and diversity training or better still to train more people from diverse cultural and linguistic backgrounds as therapists. In the short term however there is a need for greater training for the interpreters themselves to increase their own clinical
understanding and professional knowledge of therapy and bridge the gap to becoming a more helpful co-therapist in the therapeutic alliance.

The meta-synthesis is somewhat limited due to the lack of existent original research papers in this area. The papers included are from the USA, UK, Canada, Australia and Denmark, and refer to a range of clinical settings and client population groups. Similarly, variations in healthcare across the different countries also need to be acknowledged. This will inevitably impact on the way in which interpreters are used, as some healthcare systems may have more formalised ways of training and using interpreters in care settings. Furthermore, due to the disparate nature of the studies it is difficult to inter-relate all the themes that arise. It is important to acknowledge that these factors affect the experiences of therapists working with interpreters in different ways, varying dependent on country, culture, and therapeutic model used.

Despite this, the results of this meta-synthesis could be helpful for therapists to consider the impact that interpreters could have on their clinical practice. From this literature search it is evident that there is limited research in this area. The underrepresentation of qualitative research into the impact of interpreters on therapists’ experiences was evidenced by the small pool of studies identified in this meta-synthesis. With a growing number of immigrants and refugees into western countries (Engstrom et al., 2010), it is important that more research is conducted, particularly focusing on the qualitative experiences of those involved in the therapeutic relationship. A key challenge that the meta-synthesis identified was the inability to get feedback from clients. This may be due to language difficulties in carrying out this type of research. However it is important that future research addresses this gap and explores the experiences from the client’s perspective.
References


Chapter Two: Research Report
Psychological Therapy with Pakistani Clients: A Narrative Analysis of Experiences, Roles, and Relationships within the Therapist, Client and Interpreter Triad

By Shabana Bashir

Abstract

Introduction: The presence of the interpreter challenges the traditional notion of the dyadic therapeutic relationship, creating a three-way triad. Each member of the triad will inevitably have a different experience and also bring their own understanding or meaning of the triadic relationship that is formed. The current research project aimed to explore the narratives held in the triad by Pakistani clients, their therapist and the interpreter when talking about their experiences of psychological therapy, the roles they assumed and the relationships that formed.

Method: A total of six participants (two clients, two therapists and two interpreters), encompassing two triads participated in semi-structured interviews about their experiences of psychological therapy. Interviews were transcribed and analysed using a narrative voice-centred relational method of analysis.

Results: Through readings of the transcripts within and across both triads two key narrative themes emerged. These themes centred on a Power Narrative and a Culture Narrative.

Conclusion: The narrative experiences of Pakistani clients, their therapists and interpreters show that a collaborative, triadic form of therapy is incredibly complex. In particular, attitudes towards power, control and culture are predominant themes upon which the therapeutic alliance is based and balanced. The findings emphasise the need for each member being clearly aware of their roles and responsibilities within the triad.
Introduction

Current context

The UK is a multicultural society; according to the recent census by the Office for National Statistics (ONS, 2011), 12% of the population come from ethnic minority backgrounds. With increased human movement, globalisation and ease of travel, destabilisation of regimes worldwide and the resulting migration into the UK, these numbers are likely to increase in the coming years (ONS, 2013; 2015).

South Asians (India, Pakistan, Bangladesh, and Sri-Lanka) form one of the largest black and minority ethnic (BME) groups in the UK. The second largest South Asian community in the UK is Pakistani, representing 2% of the population in England and Wales alone (ONS, 2011). However, this is not reflected in the use of mental health services across the UK. Existing concerns regarding the poorer utilisation of mental health services by Pakistani and other ethnic minority groups have been widely noted (Acheson, 1998; Bhui et al., 2003; National Institute for Mental Health in England, 1993). Much of the focus and interventions for treating mental ill health among ethnic minority groups tends predominately to be undertaken within secondary care services, thus key opportunities for early intervention are often missed in primary care settings (Bahl, 1999; Bhugra et al., 1999). Furthermore, despite an increasing recognition of psychological therapy as an important early form of intervention and an increasing drive to develop and expand such services across different settings (McLeod & McLeod, 2001), an inequity of access for Black Minority Ethnic (BME) communities continues to be a well-recognised reality for many psychological therapy services (Alexander, 1999).

The UK government in 2007 announced a new initiative for Improving Access to Psychological Therapies (IAPT) for depression and anxiety disorders within the NHS (Clark, 2011; Clark et al., 2009). One of the leading priorities of IAPT services is to ensure that people’s access to psychological therapies is not hindered by their ethnicity, culture or the language they speak (Department of Health, 2008). Fundamental to making talking-based psychological therapies more accessible and available to non-
English speaking populations has been the increased use of interpreters within health care settings (Raval, 1996). With the rise in the number of BME clients speaking little or no English accessing IAPT services in recent years, use of interpretation and translation services is on the increase (Department of Health, 2009).

The presence of the interpreter challenges the traditional notion of a dyadic therapeutic relationship, creating what Lee (2003) described as a “triangle with three sets of pairs, or dyads, each one operative at a given point in time”. Tribe and Thompson (2009) develop this notion further and discuss power dynamics within triadic relationships, highlighting that power distribution within this triangle is not necessarily equal. It is ‘dependent on the anxieties provoked by working in the three way therapeutic relationship’ and influenced by a number of factors including predominant social narratives such as gender, age and attitudes towards minorities (Tribe & Thompson, 2009). These external factors can be reflected in the triad based on the type of relationships formed. This places emphasis on the centrality of triadic relationships and their importance in maintaining a helpful balance of power that facilitates positive experiences of therapy (Tribe & Thompson, 2009).

Each member of the triad will inevitably hold their own understanding or meaning of their experiences and the triadic relationship that is formed. As humans, we tend to account for events in narrative or story form, creating our own individual stories and meanings that we attribute to life events to help us make sense of our experiences (Pennebaker & Seagal, 1999). However, in a triadic therapeutic relationship little is known of the narratives that different members of the triad form about their experiences of therapy. Taking into account this added dimension, the current study aims to address this gap in understanding of the triadic narrative.

**Existing client issues**

Being unable to verbally communicate can be very daunting and “disempowering” (Tribe, 2007), particularly when accessing essential talk-based psychological therapy services (Costa, 2010). Talking to a psychologist about difficult and emotional experiences through a third person can be a very unfamiliar and challenging experience
for clients (Costa, 2010; Tribe, 2007). This can bring about a “sense of infantilisation” where the adult individual feels as limited or restricted as a young child, engendering a sense of condescension and embarrassment (Costa, 2010).

Key to psychological therapy services for clients is the ability to form and develop a therapeutic relationship with others, being able to express thoughts, feelings and needs, and sharing the meanings that they attribute to their experiences (Costa, 2010; Frank, 1982). Language plays an intrinsic role in allowing people to structure and give meaning to their experiences (Imberti, 2007; Lyons, 1981). However when a language is not shared this can prove difficult. For example, a client can be concerned that they may be misunderstood, or that a certain cultural or religious context can only be properly transmitted in its original language (Wong-Hernandez & Wong, 2002).

Language differences between client and therapist have been shown to negatively impact on a range of factors in therapy sessions (Raval, 1996; Tribe, 1999). In particular, over-simplification of complex issues due to linguistic limitations can affect the types and topics of discussion during therapy (Santiago-Rivera, 1995; Seijo et al., 1991). This can result in poor client engagement and retention of clients (Hillier et al., 1994), and mistrust towards services (Raval, 1996; Tribe & Morrissey, 2003).

There is a limited amount of exploratory client-based research looking at the presence of interpreters across various therapeutic encounters. A study by Baker et al., (1996) has shown that when clients are allocated an interpreter to help with expressing difficult feelings and emotions in a second language, they report much higher satisfaction levels and overall better outcomes and experiences. However although clients reported feeling more comfort and ease during therapy sessions when an interpreter was present, there was still a measurable discrepancy between the quality of therapy possible for these clients as opposed to a linguistically proficient client (Kline et al., 1980).

Conversely, despite the advantages of having an interpreter present, some authors have noted that an extra person in the therapeutic alliance can present unique challenges of their own. For example, interpreters from a similar background may carry cultural, political or religious baggage that hampers client disclosure of sensitive personal views.
and information (Tribe & Raval, 2003). Similarly, clients may worry that the interpreter could be judgemental of their feelings and be concerned at the level of professionalism and confidentiality of the interpreter (Engstrom et al., 2010).

However, there is no current research which examines how clients’ narrative experiences relate to the experiences of others within such triadic therapy. Where research has been carried out, it has been outside the UK context, adding to the necessity of the current research.

**Existing interpreter issues**

Throughout the existing research interpreters are shown to play many different roles, ranging from acting as a mere translating machine (Miller et al., 2005) or “black box” (Westermeyer, 1990) to being a fundamental part of a three-person alliance, almost a “co-therapist” (Raval & Smith, 2003). Leanza et al. (2015) adopt a continuum model to explain and organise these roles and functions. These range from alliance with the client as a co-client who expresses the client’s needs and cultural narrative, to alliance with the therapist and an extension of the wider healthcare system.

Interpreters are therefore required for a range of services, not limited to mere translation. In some cases they play a vital role in interpreting cultural context, conditions, and structures, and explaining the impact of these on the client to the therapist (Becher & Wieling, 2015; Engstrom et al., 2010). The role the interpreter takes is therefore dependent on the client group, and clients from different backgrounds will have different expectations and requirements (Hillier et al., 1994; Raval, 1996). However, little is known about which of these roles are perceived as helpful or wanted by each member of the therapeutic triad. To do this, it is important to know each triad member’s perspective and narrative account of the therapy.

Depending on the various expectations and demands placed on the interpreter by themselves and others, the interpreter’s experience can be a very stressful one (Doherty et al., 2010; Green et al., 2012; Holmgreen et al., 2003; Leanza et al., 2015; Yakushko, 2010). Interpreters could themselves feel considerable discomfort when exposed to
traumatising or stressful client accounts, and may not feel qualified or sufficiently trained to deal with difficult and complex feelings (Raval, 1996). Interpreters in some cases may be from a similar background to the client or share similar experiences, for example being expelled from a homeland or tortured in a war zone (Tribe, 2005). This could lead to large amounts of stress being placed on an interpreter who may not have been willing or prepared to interpret in that context, and ultimately these factors could prove detrimental to the effectiveness of the therapeutic alliance as a whole (Engstrom et al., 2010; Miller et al., 2005; Mirdal et al., 2012).

The quality of the interpretation itself is a key factor in maintaining the therapeutic alliance and delivering effective therapeutic outcomes - interpretation is a difficult discipline to master, especially when translating and transmitting psychological terminology or culturally specific information from one language proficiently into another (Lopez, 2002). Interpreters can make a variety of mistakes or lose essential meanings in the translation process (Farooq & Fear, 2003). Knowledge of vocabulary and understanding of a wide variety of cultural contexts is an essential skill not necessarily shared by all interpreters available in a healthcare setting (Kaufert & Putsch, 1997). Therefore, the role of the interpreter in quality of care is crucial.

Interpreters are often seen as somewhat interchangeable by their peers in the therapeutic alliance, and unqualified in therapeutic matters (Kaufert & Putsch, 1997). This, and the practical organisational structure of healthcare systems, results in the selection process for interpreters being made on a basis of rota, need and availability, rather than a more careful consideration of matching an interpreter’s specific skills to a therapeutic triad (Jacobs et al., 2004).

Despite some of the challenges associated with the use of interpreters numerous research studies have shown the use of interpreters to yield positive clinical outcomes for clients including a reduction in symptoms (d’Ardenne et al., 2007), length of stay in hospital and readmission rates (Lindholm et al. 2010).
Existing therapist issues

Existing literature shows that therapists’ experiences within a therapeutic triad are often positive and helpful, with some exceptions (Engstrom et al., 2010; Miller et al., 2005; Mirdal et al., 2012; Pugh & Vetere, 2009; Raval & Smith, 2003; Yakushko, 2010). Research studies have described how the interpreter in particular provided a useful cultural bridge to aid understanding of the client within an appropriate context (Miller et al., 2005, Yakushko, 2010). Also, the interpreter was often seen by the therapist as a co-therapist and an equally important factor in the effective delivery of care (Raval & Smith, 2003). Therapists generally recognised that their job would not be possible when dealing with clients with language barriers unless they entered wholeheartedly into a triadic therapeutic relationship (Mirdal et al., 2012).

Some therapists, however, felt hesitant and apprehensive about the changing dynamic from a dyadic to a triadic therapeutic relationship (Bercher & Wieling, 2015; Raval & Smith, 2003). The introduction of an interpreter and the presence of a client who cannot directly communicate can cause some therapists to feel undermined and disempowered in their therapy session, due to the added linguistic barriers (Kline et al., 1980; Tribe, 1999). They may also feel the need to justify or explain aspects of their therapeutic approach to the interpreter, or perceive that the interpreter is judging their professional skills or cultural understanding (Hillier et al., 1994).

Therapists have reported feeling that cultural or linguistic familiarity between client and interpreter can be helpful to foster trust and understanding, but can at times make the therapist feel left out of the therapeutic relationship (Becher & Wieling, 2015; Leanza et al., 2015). Bonding between all members of the triad is therefore seen as helpful to the alliance, but bonding between two out of the three members can severely affect the relationship and consequently the therapy (Mirdal et al., 2012).

Therapists may feel that the quality of interpretation is low and therefore affecting the therapy as a whole (Engstrom et al., 2010; Miller et al., 2005; Mirdal et al., 2012; Pugh & Vetere, 2009; Raval & Smith, 2003). This could be due to a lack of trust developed between the two professionals, where the therapist has doubts over the interpreter’s
knowledge of the target language or ability to translate more complex themes effectively (Engstrom *et al.*, 2010; Miller *et al.*, 2005; Mirdal *et al.*, 2012; Pugh & Vetere, 2009; Raval & Smith, 2003). A therapist may even have a rudimentary understanding of the client and feel that the interpreter is omitting or distorting certain information from or to the client (Pugh & Vetere, 2009). Such fears may become more profound if the therapist is not used to working with clients from other backgrounds (Dezelueta, 1990).

**The current study**

It has been established thus far that the use of an interpreter in overcoming linguistic barriers to psychological therapy has a profound effect on the dynamics of the therapeutic relationship. Existing literature provides some insight into the experiences of members of a triadic therapeutic alliance, and helps to develop an understanding of the role and potential impact of the interpreter.

Much of the existing literature examining the therapeutic relationship has focused on the experiences of the therapist, client or interpreter in isolation, rather than the triadic set of relationships that are said to occur during therapy. To the researcher's knowledge, only one study by Mirdal *et al.* (2012) has focused on the views of the triad; however the study only asked participants to identify curative and hindering factors associated with psychological therapy rather than exploring participants’ overall narrative experiences of therapy or the roles and relationships that occur.

Despite the size of the UK Pakistani population, it is not a widely researched group in the context of linguistic barriers to psychological therapies. A limiting factor to this could be the lack of first-hand knowledge of languages indigenous to Pakistan among potential researchers in this field. Being fluent in a number of community languages gives the researcher a unique position to be able to explore the narratives that Pakistani clients hold when accessing psychological therapies.

Over recent years the use of more narrative analysis methods as a form of qualitative methodology has significantly grown in interest amongst researchers (Robert &
Shenhav, 2014). Narrative analysis is concerned with the way stories are not only verbally reported but also constructed and co-constructed in conjunction with others, and the influence of various social and cultural contexts on such stories and their methods of reporting (Bakhtin, 1981).

In the light of this, the current study is interested in developing a narrative account of the individual and combined experiences of the members of the triadic alliance. Given the natural inclination for people to frame meaningful experiences in the form of stories or narratives (Bruner, 1996), this study will construct a narrative of therapy as experienced in a triad by each member. In a cultural context, it is even more meaningful to obtain narrative accounts, as these are more readily formed and shared by people who are accustomed to using narrative forms of communication (Howard, 1991). This study is also interested in the ways in which these narratives are co-constructed and interact with each other. Ultimately these stories will form distinctive voices for each member of the therapeutic alliance, and may form a united voice in some cases.

Research question

What narratives do Pakistani Clients, their therapists and interpreters hold about their experiences of psychological therapy, the roles that they assume, and the relationships that form? What influences how these narratives are constructed and co-constructed?

Method

Qualitative approach

To achieve the aims of the study and develop an understanding of the triadic experiences of Pakistani clients, their therapist and the interpreter, a qualitative methodology was chosen. Qualitative methods allow for an in-depth exploration of people’s lived experiences, particularly in novel areas (Barker et al., 2002). A number of approaches to analysing qualitative data were considered, including Interpretative
Phenomenological Analysis (IPA), Discourse Analysis (DA) and Narrative analysis. According to Harper (2012), there are a number of factors relevant to selecting a methodological approach. In addition to selecting a method congruent with the research questions and aims, other key factors include the preferences and interests of the researcher, and the kind of focus that the researcher wishes to have (Harper, 2012).

**Considered Approaches and the use of Narrative analysis**

The interest and focus of the current research centred on the stories told by individuals and how these connected with the stories of other members of the triad. It was deemed important to take into account wider social and cultural influences and understand how participants formed narrative accounts of their experiences, rather than simply focusing on the individual experiences in isolation.

Given this aim it was felt the use of IPA, with its idiographic focus, would have detracted from the intended focus on collaborative stories and remove aspects of narrative structure and cultural resources from consideration (Parker, 2005).

Whilst DA places great emphasis on narratives and stories, it is more concerned with the use of language, particularly how individual meaning is constructed through the use of language and words (Coyle, 2007). It was therefore felt that the focus on language and discourses in DA meant that there would be reduced inference about any wider stories being told, thus limiting the use of this approach in the current research. Narrative analysis with its particular focus on stories that people hold and share about themselves and others therefore appeared to complement the aims of the current research. This also appeared to be congruent with the suggestions made by Harper (2012) who mentions that if the focus and interest of the research is in the stories told by individuals and communities, it is recommended to use narrative analysis.

Furthermore the interest and focus of the current project developed beyond the individual accounts and personal experiences to include the influence of wider societal factors, particularly the role of culture, traditions and historical contexts on the development of triadic narratives. With its focus on shared narrative accounts of groups
beyond the individual (Mills, 1959), the narrative approach allowed the researcher to gain an insight into how wider familial, community and societal factors give shape to accounts of individuals lives and personal identities. Therefore taking a narrative approach enabled the researcher to understand more deeply how individual narratives are constructed and influence a co-constructed narrative of a three-person triad.

There are several methods of narrative analysis (Murray & Sargeant, 2011). With the specific interest in relationships within triads, a narrative voice-centred relational method of analysis, particularly the listening guide (Brown & Gilligan, 1992; Gilligan et al., 2003) was used. This allowed the researcher to explore narrative accounts in the context of individual, triadic, or wider societal or cultural relationships (Mauthner & Doucet, 1998).

In its focus on how societal factors influence narrative accounts, the current study is framed within a social constructionist epistemological positioning (see Appendix C for further information).

**Ethical Approval**

Ethical approval for the study was granted by the East Midlands Ethics Committee in January 2015. Ethical approval documents can be found in Appendix D. Additional approval was also sought and granted by each of the NHS Trust Research and Development departments in which the study took place.

**Recruitment procedure**

Improved Access to Psychological Therapy (IAPT) services across a number of NHS trusts were approached to assist with recruitment for the research. The geographic areas were targeted due to the diverse ethnic populations working and residing there. Service managers from the selected IAPT services were initially contacted to explain the purpose and nature of the research. IAPT services were selected due to the consistency of pathway to the service. Also due to time constraints and the decision to interview clients at the end of therapy, it was felt that focusing on IAPT services would make
recruitment more feasible due to the time limited nature of the therapy. As the study was focusing on therapeutic relationships developed between the participants, high intensity therapists were selected due to the less structured nature of their work and their opportunities over the timescale to develop a therapeutic relationship.

Written introductory materials to the study were prepared and disseminated by service managers to all IAPT high intensity therapists working at these sites, informing them about the nature of the research and ethical considerations (Appendix E contains details of ethical considerations).

Identification of triads was initially done through consultation with the IAPT therapists from these sites. Therapists were asked to identify Pakistani clients they were working with in current or recently completed therapy cases using the aid of an interpreter. Therapists were asked to disseminate introductory material to their Pakistani Clients and the interpreter. In some cases, the interpreting services were contacted directly by the researcher and sent introductory material which included a Participant Information Sheet and a Consent to Contact Form. Participants were instructed to complete this form if they were interested in participating and happy to be contacted by the researcher. Introductory materials were produced in English (Appendix F), Hindi (Appendix G) and Urdu (Appendix H) to encompass the written languages of the participant groups researched.

Participants who agreed to participate in the study were met by the researcher in person. They were asked to confirm that they had fully understood the nature of their participation in the study and written consent in participants’ languages (Appendix I, J and K) was sought prior to any interview taking place. Interviews were only conducted with participants following the end of therapy. At the end of each interview, the participant was offered a £20 gift voucher for their time. A detailed diagram of the recruitment process can be seen in Figure 3.
Figure 3: Recruitment flow chart.

Inclusion and Exclusion Criteria

Participants were selected on the basis that they were Pakistani clients, psychological therapists or interpreters engaging in psychological therapy within IAPT services. Therefore, the sample can be considered purposive (Cohen et al., 2003). Prior to
participants being approached to take part in the study, a set of criteria was considered and applied as shown in Appendix L.

Sample

A total of six participants took part in the study, encompassing two triads. Thus a total of two clients, two therapists and two interpreters participated in the study. The clients, interpreters, and one of the therapists were all from Pakistan or Pakistani backgrounds. The remaining therapist was from a Caucasian English background. One set of clients and interpreters spoke Urdu, the main language of Pakistan, and the other set spoke Mirpuri, a dialect of the Azad Kashmir region of Pakistan. A description of the triads can be found in Figure 4. All participants have been given pseudonyms.
Triad One

<table>
<thead>
<tr>
<th>Client</th>
<th>Haider was a Pakistani male and spoke Urdu. He had received therapy through an IAPT high-intensity therapist for experiences of depression</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapist</td>
<td>Jane was a Caucasian, English female who spoke English. She had worked as an IAPT high-intensity therapist for 2 years.</td>
</tr>
<tr>
<td>Interpreter</td>
<td>Farida was a Pakistani female who spoke both Urdu and English. She had worked as an interpreter for 15 years, across different settings. She had been translating for IAPT services for the past 2 years.</td>
</tr>
</tbody>
</table>

Triad Two

<table>
<thead>
<tr>
<th>Client</th>
<th>Ibrahim was a Pakistani male who spoke Mirpuri, a dialect of the Azad Kashmir region of Pakistan. He had received therapy through an IAPT high-intensity therapy for experiences of depression.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapist</td>
<td>Suleiman was a Pakistani male who spoke English. He had worked as an IAPT high-intensity therapist for 4 years.</td>
</tr>
<tr>
<td>Interpreter</td>
<td>Yusuf was a Pakistani male, who spoke English, Urdu, and the Mirpuri dialect of the Azad Kashmir region of Pakistan. He had worked as an interpreter for 20 years. He had been translating for IAPT services for the past 3 years.</td>
</tr>
</tbody>
</table>

Figure 4. Description of triads

Materials

As we live in a world full of narratives, researchers have different options and sources of data to draw upon (Murray & Sargeant, 2012). Given the time constraints of the thesis the semi-structured interview format was utilised as they aimed to answer the research questions through an interview guide, yet allowed for flexibility depending on each participant’s varying narrative account of psychological therapy. An interview
The interviews lasted between 25-45 minutes and were audio-recorded and transcribed verbatim. Interviews conducted in Pakistani languages were transcribed by the researcher and translated into English in collaboration with a professional translator. The translations were also verified for accuracy by an independent company offering translation services (Appendix N).

**Data Analysis**

A voice-centred relational method of narrative analysis, the *listening guide* (Brown & Gilligan, 1992; Gilligan *et al*., 2003) was used to explore the narratives that clients, their therapist and the interpreter held about their experiences of therapy.

The listening guide enabled the researcher to understand the way clients, their therapists and the interpreter spoke about themselves through individual and multiple voices. It gave attention to ‘relationships with oneself and with others’ (Gilligan *et al*., 2003). The listening guide required four readings of each transcript, each with a distinct focus.

- **Reading 1:** This was a reflexive reading of narratives, focussing on themes, patterns, and the stories being told.
- **Reading 2:** The i-poem was a list of all direct first-person ‘I’ statements, noted down in the exact order they occurred in the transcript.
- **Reading 3:** This was a reading for relationships and interactions. Subjects were studied through the transcript and aspects of their nuanced relationships noted.
- **Reading 4:** This focused on structured relationships and dominant narratives. The researcher looked for overarching concepts which linked the small interactions to the bigger picture, including cultural contexts and wider societal
discourses in which the narrative was embedded.

Overall the four readings give emphasis to the multifaceted nature of narratives and helped to build a collective account of triadic experiences of psychological therapy, the roles that members assumed and the relationships that formed. These four readings were then written up in the form of two narrative case studies as suggested by Mauthner and Doucet (1998), one representing each triad.

**Research Quality and Integrity**

Yardley (2000) highlights four essential criteria for assessing the quality of qualitative research including sensitivity to context, commitment and rigour, transparency and coherence, impact and importance. See Appendix O for details of how the researcher maintained awareness of these criteria throughout the research process.

**Results**

Through readings of the transcripts in accordance with the analysis method highlighted by Brown and Gilligan (1992), two key narrative themes emerged; a Power Narrative and a Culture Narrative. The Power Narrative concerned the power dynamics in the different relationships, and how each member positioned themselves and others in the triad. The Culture Narrative centred on how cultural contexts and beliefs influenced roles, interactions, relationships and understanding. Each theme is discussed using illustrative quotes, pictures of stone positioning and sections of participants’ i-poems (see Appendix P for quotes in Urdu script). As recommended by Brown and Gilligan (1992), the results included thoughts the researcher had whilst analysing the data.
Power Narrative in Triad One

Jane (therapist) – powerlessness of “authority”

Jane started the interview expressing her passion for psychology developing from an interest in “helping individuals” and a fondness of the one-to-one nature of psychological therapy.

In terms of my experiences of psychological therapy, erm I find that sometimes with the use of an interpreter it’s not as personal as I would like for it to be. Erm it almost feels like there is an extra person in the room erm and obviously when I am engaging in psychological therapies with individuals on a one-to-one basis it feels a bit more personal, it feels a bit more therapeutic.

Jane seemed to be positioned as the leader in the triad and used the words “authority” and “somebody of a high positioning”, when she described how others in the triad saw her role. As the interview progressed, Jane described feeling somewhat concerned by the lack of control that she had over the therapy sessions.

It doesn’t feel like you’re controlling the outcome that you want in your sessions, giving the questions to achieve what you want…

Jane described a sense of ownership over the therapy sessions, with her frequently referring to them as “my therapy”, “my sessions” or “my work”. With the added dynamic of the interpreter, Jane further described a sense of powerlessness over the relationship she was able to form with the client. This view of Jane really comes through the first part of her i-poem.
I find that sometimes with the use of an interpreter it’s not as personal
I would like for it to be
I am the one engaging in psychological therapies with individuals
I think sometimes I find erm with the interpreter
I am having to repeat questions
I am trying to ask
I gauge that by what the client is saying
I have to give myself extra time
I am using an interpreter
I mean in terms of ultimate outcome
I can obviously achieve
I wish to achieve
I feel
I haven’t had the opportunity to build that one-to-one therapeutic relationship
I would do

The interpreter’s close relationship with the client, almost positioned Jane as an “outsider”, which is reflected through the readings of Jane’s interview and positioning of her stones (Figure 5), where she placed the client and interpreter closer to each other.

I felt like there was a sense of distance between myself and the clients themselves. I felt like the client seemed happy to engage with the interpreter, but it almost felt like I was outside and the actual session was going on between the interpreter and the client, as opposed to me and the client with use of an interpreter, erm so it was quite challenging, quite a difficult situation to be in.
These anxieties seemed to be centred on not being able to speak or understand the client’s language. Jane expressed feeling that the shared language between the client and interpreter helped with developing familiarity between the two and enhance trust.

*It almost felt like I was just asking them questions and the interpreter was doing what technically I should be doing, if that makes sense, because they were able to have that one-to-one kind of conversation. It almost felt like, sometimes it can feel like you’re an outsider.*

This further comes through in her interview where she attempted to provide reasons for why she felt the client and interpreter formed a closer relationship.

*I think it was language and the background. There seemed to be some familiarity even though there wasn’t because that was the first time that the client had met the interpreter, so I think the use of common language maybe aided that therapeutic alliance they had built and I think that whole trust that they were able to gain because of that they were maybe opening up to each other.*
Jane appeared to wish to develop a more direct relationship with the client, without the need for an interpreter. Particularly through the third and fourth readings on relationships, despite acknowledging the importance of the interpreter’s presence, Jane went on to suggest alternatives to the interpreter’s presence such as language courses for therapists, possibly in an attempt to reinstate the dyadic relationship with the client.

*I do recommend it, I purely recommend it because I feel like without recommending it, it would feel like you were excluding certain people from psychological therapies and services cause of issues like language barriers. So I think it’s essential that we provide a service but I think we need to think more clearly about the quality of the service we are providing and what training needs we may have, which may include language, small short language courses…*

**Farida (interpreter) – The awakening of power**

In contrast to Jane’s narrative, Farida started the interview expressing doubts in her own abilities, which placed her in a position of powerlessness in the amount of influence she may have had over aspects of the therapy. This comes through in the story of her role in the triad, where she spoke about herself as “just a translator”. Farida placed emphasis on her limited understanding of certain technical aspects of psychological therapy. This seemed to influence the relationship dynamics in the triad, whereby Farida felt that she only had a purely functional relationship with Jane based on translating.

*When I initially started, again like I said my understanding was a bit limited, it was just about interpreting for the therapist and that was it. Even though again it is about interpreting because we can’t, we can’t get too personal with the client and it is about relaying information.*

Through further readings of the interview, Farida goes through a process of power awakening, where she began to place emphasis on her cultural expertise over her linguistic expertise, which she felt was a positive influence and contribution to the
therapy process. She placed importance on her ability to not only get responses from the client through this increase in power and control, but felt this helped the therapeutic process through her own contribution. This is reflected in the following extract from her i-poem:

I've positioned all of us
I feel as if the therapist was obviously very helpful
I relayed to her
I've kind of put everyone in the same, next to each other
I've positioned myself
I do play quite an important role
I'm interpreting exactly
I'm more or less the voice of the client
I had to ensure
I interpret everything

In her placement of stones (Figure 6), Farida positioned herself closer to Haider in terms of understanding, contribution, helpfulness and relationship. This closeness with Haider seemed to be based on cultural similarity and understanding.

I think because me and the client are from the same, a similar background, similar life experiences to be honest, I was able to understand the client more. So I think in terms of understanding what my relationship with the client will probably be a bit better and my understanding with the client and the clients understanding with me would have been better than the therapist
Farida almost started to position herself as an advocate for Haider. She appeared to feel an affinity towards him in a way that was protective and inclusive of their relationship, and also became protective of their collective culture. She placed this view in socio-political context, where she felt her culture and religion are not understood by the “west”.

A few people in my community are aware of it and I don’t think they see it in a positive light, er because again like I said they see mental health more as, you know something that people have no control over, therefore there’s, you know, there’s no point going to a therapy session, when the only thing that can cure it is rituals, religious rituals, so it is kind off frowned upon, hence not a lot of people from my community come because people in the west just wouldn’t understand this if you know what I mean.

**Haider (client) – compelled powerlessness (“majboori”)**

Haider’s narrative account illustrated his position of powerlessness within the triad from the beginning. He began the interview by emphasising his limited English proficiency and stating that he was “majboor” (compelled) to seek help.
My opinion is it’s not a matter of good or bad, it is a matter of need. Because we find speaking English difficult, and then I got ill, then I went for treatment, so obviously when you go to the doctor sometimes they can give you medicine but sometimes there is a situation where you need therapy and then we have to do all this. So it is a need, I never thought of it in terms of good or bad.

When Haider spoke about himself he often undermined his own feelings. He continued throughout the interview to refer to Jane as a “doctor”, almost placing her as a distant figure due to her professional status. This almost seemed to further place Haider in a powerless position where he was “totally reliant” on the interpreter to interpret accurately. This almost created a sense of anxiety about the accuracy of the interpretation.

In translation, if there were any obstacles, then I don’t have enough understanding that I can say whether she (the interpreter) translated wrong or right. So this is the problem, this is the dependency. It depends on- because I’m saying something, she (interpreter) is saying something to the doctor, then the doctor is saying something, and then I’m getting the message. So everything is going through her and I am totally reliant on her that she is telling the right things that the doctor is saying. I mean, I understand some things but when I am in front of the doctor I feel a bit nervous, and also I was ill as well, so that is the point.

Haider saw the interpreter as a vital friend and support, based on them being linguistically and culturally similar. Throughout the interview Haider expressed gratitude and thankfulness to the therapist and interpreter, giving a sense of indebtedness.

you see I couldn’t speak to her directly that much, apart from saying thank you...

Both of them helped me, because- because without her, without the interpretation I couldn’t do it, and without the doctor I couldn’t do it...
In the context of the triad Haider seemed to hold a silent voice and very much placed himself as a passive recipient of “illaaj” (treatment). He frequently spoke about “majboori” (compelled to seek help), which could be reflective of his feelings of powerlessness and lack of control within the triad.

You are helpless (in language), you are ill, you have gone to get treatment… so as much as someone can be understanding towards you, the better. But if someone doesn’t understand you there is not much you can do…

Whilst Haider demonstrated a position of powerlessness within the triad, by the end of the interview you saw Haider going through a process of enlightenment over his cultural beliefs. This sense of enlightenment came through being educated by the therapy.

In my future life, as I said at the very beginning, I have learnt something personally about depression and mental health. I will keep this in mind. Because I- If I see anybody with this kind of issue then I will be able to advise them and counsel them…

Culture Narrative in Triad One

Jane (therapist) – “western” cultural identity and influences

Jane identified herself as being “western” and framed her narrative within this cultural ideology. This is further reflected in her i-poem and her positioning of stones (Figure 7), where she positioned the client and interpreter closer together.
I think psychological therapy is beneficial
I think my understanding
I think probably in terms of my parents
I think for me in terms of western ideologies
I class myself as a very western individual
I've been educated
I think that has formed my own understanding of mental health

Figure 7. Culture Narrative: Jane’s positioning of stones

Jane suggested that this closeness in the relationship between the client and interpreter was influenced by their shared cultural background. This is reflected in the justifications given by Jane for why she was an “outsider” in the triad, whilst the key relationships being formed were between the client and interpreter.

I think the cultural background, common understanding, that probably trust factor of trusting somebody who is you know within certain cultures is classed as one of your own. Erm language issues obviously I think impacted on that.

In her understanding of mental illness Jane took what she described as a “western view”. Jane seemed more concerned about services being adequately delivered than different communities being able to access psychological therapy, stating that “…it’s almost looking at the quality of service we are providing rather than the quantity”.

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Farida (interpreter) - protection of eastern cultural identity and influences

Farida seemed to be influenced by her cultural and religious background and understanding. Her views of mental health were also deeply embedded in her cultural understanding.

so my understanding is, erm I mean you’ve got the religious aspect of it and the cultural aspect of it as well. Where in my religion we do believe in the jinn (spirits) say for example and we do believe in er yeah that individuals are you know possessed say so to speak. Er and we believe in karma and bad luck and stuff like that, er so that would be our understanding of it, but we, we, it, I mean our religion itself people tend not to use therapy because they find other, other medications you know like rituals and praying and things like that might actually help better.

Farida’s belief in the importance of her culture and religion seemed to influence her approach to the therapy triad. She almost saw herself as a protector of her culture and community, whereby her role became that of a cultural advocate. Perhaps this positioning influenced the kind of relationship Farida was able to develop with the therapist.

Within the actual culture and village mental health is frowned upon so a lot of people will suffer from mental health in silence, and they won’t, they won’t seek support, advice, help or even not attend therapeutic sessions because it’s frowned upon and that why I think when someone is going through depression they isolate themselves.
Haider (client) – awakening of new cultural identity and influences

Haider affiliated himself with the culture of his community, but recognised its flaws. He was able to see culture and religion separately and acknowledged where they contradicted.

Actually, I will tell you honestly. In our religion, maybe there is something written. But the way we follow our religion, if you go to a traditional local cleric, and ask him what is the religious standpoint or what does Islam say about this (mental health), he will just say that you go and read these verses, go home and sit down and read these other verses for protection, or he will say that this is a very serious matter and you have been possessed by a spirit, and will beat you maybe, or send you to someone who might burn you or something like that. So these are not actually religious- this is not our religion at all. This is just cultural, superstition, that is all.

Although appearing somewhat dispassionate about the therapy process, Haider still showed signs of appreciating and being reliant on the presence of someone from his own cultural background in therapy.

You are in treatment, you are ill, you are with the doctor. But some things were nice, as I mentioned that sometimes you would get a good interpreter who is from the same country as you, come over from the same country, so there is a bit of- you feel that if someone of your own background understands you, and then that person is telling the doctor exactly the right thing, then you get reassured.

This is also reflected through positioning of his stones (Figure 8), where Haider placed the interpreter closer to himself in terms of understanding and relationship.
When talking through the progression of his therapy journey, Haider described a process of enlightenment, whereby psychological therapy not only impacted on his mental health but also his sense of identity and sense of self. He spoke about thinking differently about certain attitudes that he once held about issues such as mental health and treatment.

*In my future life, as I said at the very beginning, I have learnt something personally about depression and mental health. I will keep this in mind. Because if I see anybody with this kind of issue then I will be able to advise them and counsel them, where they need to go, that treatment is available, that it’s fine, that there are people from our own culture there who will help you, and they can come back home also, like that. So this is what I have learned. And I have learnt that this country in which we live contains very good people who will help you, if you aren’t very confident to speak the language then you can still get help… I did my driving test with the help of translation, and now I drive. So this is a very good country, and I am very grateful that I was ill and it was a very bad illness but now I’m absolutely fine. And I got the chance, you know, to speak to someone from my own culture about it, I received treatment in my own language, this isn’t possible everywhere.*
Power Narrative in Triad Two

Suleiman (therapist) – power through professionalism

Throughout the different readings of his interview, Suleiman appeared to be in a position of expertise within the triad. Whilst valuing the contributions and interactions of the interpreter and client, these interactions seemed to be appreciated in the context of clear boundaries set within the therapy session.

The interpreting of what I was saying, and he was well within those boundaries. And the role of the patient was just to tell me how it was for him. And he clearly did that, and he clearly stayed on- he adhered to the agenda, he stayed with it.

It was interesting to see how this position of power was directly or indirectly personified in the therapy sessions.

I mean, you know, it was a GP surgery, it was, it was a Primary Care Centre, I was sitting in the GP’s seat, I was in a position of power, ok, I was- I had formal attire on, ok, they saw me as a, as a clinician, I believe. Yeah? Someone with knowledge about mental health, yeah.

You got a sense of professional expertise, particularly through reading three and four, where Suleiman talked about the relationships with other members of the triad. At various points in the interview he mentioned how he could have been even closer and friendly with the other two members, particularly the client, but his professional position held him back.

…we were both professionals. So, yeah. It was a close relationship but, the client couldn’t be like that, because I could actually go and pray with, with him (the interpreter). I could, I didn’t. I could do if I wanted to. Ok. But I couldn’t invite the patient, ethically …because there was an ethical barrier that I couldn’t cross over. So that’s where I would leave it.
He described having a close relationship with the interpreter in particular, which is reflected though his positioning of the stones (Figure 9).

![Figure 9. Power Narrative: Suleiman’s positioning of stones](image)

Again this closeness is described in the context of professional status, with the interpreter also being a professional and having self-taught knowledge and expertise of different dialects compared to Suleiman. This almost placed the interpreter in a comparable professional status.

... he was able to explain things and I was able to learn some of the dialect stuff. Um, and he said that he was born in this country, I mean he’s probably about in his fifties now, his son’s a doctor and what I- he was born in this country or he came in this country early age, his, his dialect wasn’t strong and he was self-taught, so he self-taught himself to speak at quite a high level that he could advocate for people at courts professionally and I thought that’s- I thought that was amazing.

The slight distance in relationship with the client was spoken of in terms of this professional barrier, which was personified through the following extract of Suleiman’s i-poem:
I could actually go and pray with him (the interpreter)
I could
I didn’t
I could do if I wanted to
I mean
I didn’t connect with the patient
I couldn’t cross over
I would leave it

Yusuf (interpreter) – power through professionalism

Yusuf also spoke about his professional expertise, particularly his ability to “explain sometimes higher level concepts in two languages”. He appeared to position himself as a cultural broker, as the person who brought unique expertise and in his view an equally important perspective. This comes through in his story of his role in the therapy triad.

…to a certain extent the therapist saw me as not only as an interpreter but also somebody to consult on certain cultural issues. There were times when the therapist would actually say something in English and then sort of ask me to reword it with cultural sensitivity. So in that respect I saw myself as more than just a translator. And similarly for the client, I think the client wanted me to have understanding and sympathy of what was being said before I relayed it back to the therapist, so even from the client’s point of view I feel I wasn’t just a translator.

This is further reflected through his positioning of stones (Figure 10) in terms of helpfulness and active contribution to the therapy process, whereby he positioned himself equal to other members of the triad.
Yusuf appeared to place a high value on his professional contribution to the therapy, which explains his opinion of a more shared power dynamic in the triad.

*I think obviously if you go into a session and it’s quite easy early on to develop a rapport with the therapist and also with the client, then that’s very helpful, it lends to quite a smooth for me as an interpreter. Because obviously I’m trying to facilitate communication between these two parties, and so I think it just boils down to whether or not that rapport is possible to develop. And it depends, really, as well, on the particular difficulties that the client is facing, why they’ve been referred to this therapy because you know some people are genuinely very distressed and they cannot engage very well. Especially to start with. And that can be very challenging. Especially with the added step of having an interpreter, the therapist might have certain ideas they want to put in the client’s mind, and they have to do it through me. So I do sometimes feel that there’s a bit of pressure and almost I’m trying to convey the therapist’s messages to the client, and also I’m trying to get on side - not befriend, but get on the client’s side so that they actually can respond to me.*

**Ibrahim (client) – powerlessness through indebtedness (“ihsaan”)**

Ibrahim appeared to see himself as indebted in some way to the help and expertise of the other members of the triad. He was very grateful to Suleiman and Yusuf, who he felt had helped him greatly. His admiration and appreciation took different forms,
where he was in awe of the interpreter’s language skills and compassion and appreciative of the therapist’s ability to understand and advise him.

The way in which he was trying to help me by explaining to the therapist, I really felt he was helping me from his heart and I also felt it with the therapist, so they’re more or less close. The reason why I felt it with the therapist was because they were helping me and I felt they understood me well... I’m very grateful to both of them.

Despite the interpreter feeling that he was closer to Ibrahim because of cultural awareness and language skills, Ibrahim in his stones placement indicated that the therapist understood him best (Figure 11).

![Figure 11. Power Narrative: Ibrahim’s positioning of stones](image)

By the end of the interview, Ibrahim felt he had benefitted greatly not only in terms of treatment but also in terms of his knowledge of mental health issues. This seemed to give him a sense of increased power and self-confidence.

I’ve learnt a lot of things. Firstly I have learnt that you shouldn’t put too much pressure on your mind. You should think a bit first, whatever you think and feel. Now some of the questions they asked me they repeated and when they repeated questions they gave me the chance to think about what is happening to me and how I can help myself, so mostly they gave me the capability that I could think for myself. I think I should put less pressure on myself and more things like
yoga, relax my body a little and lessen the burden on my mind and you never know help myself, I can help myself, help save myself.

Culture Narrative in Triad Two

Suleiman (therapist) – conflict of cultural identity

Suleiman seemed to have a mixed cultural identity. He referred to cultural closeness with people from his own Pakistani culture describing “more of a community feel” with people from a Pakistani background, but at the same time declared that “culturally I’m British”. However, despite declaring his British identity, Suleiman went on to talk about his past experiences and affiliation with the Pakistani community. He spoke about a city he had lived in where he felt accepted and immersed in the Pakistani community, compared to the community in which he currently resided.

...because it’s a Gujrati dominant Muslim environment so they have a different feel, I’m not from that community, I’m not from that relation, so I don’t have that social mix.

He further suggested that one of the main reasons why the therapy with Ibrahim and Yusuf was so successful and positive was because all three members of the triad had a shared background and were from the same community.

I think that had a spiritual kind of connection to it, not that I- we never talk, we don’t talk about the religious aspect but it was coincidental... You know, and all that kind of stuff so um, that was another thing. We were all Pakistanis and we all were from the same geography, we were all, so you’ve got a lot of- a lot of things factors playing in there.

Suleiman described admiration of his ‘liberal’ uncle, compared to his own culturally traditional family, however it was not clear whether this was due to cultural reasons or simply because they had a more assimilated western view of mental health.
I think it has a lot to play with the dynamics of the household. So if the household is more liberal minded like my uncle’s family, um, they’re more understanding, they’re more liberal.

Suleiman shared moments of cultural understanding and positioned himself as a cultural advocate. He highlighted reasons why Pakistani communities did not access psychological therapy, including family dynamics, lack of understanding, trust issues and over-familiarity.

…maybe it’s got something to do with dynamics of the household, maybe it’s got something to do with awareness of services that could help, particularly culturally specific services. They’re, they’re, everyone’s aware of mental health probably, I guess, everyone’s aware that they might feel low, they might not be aware of - maybe- bit more subtle conditions like OCD, phobias, perhaps PTSD, they’re probably more aware of the depression but then, ok I can go to my GP, ok I can get medication, but to go to a therapist, I think that’s a huge jumping block because then: Can I get a therapist that’s female? Can I get- Will I get a therapist that’s Asian, will that therapist know somebody else? Coz that’s been something that’s happened to me, I’ve- I’ve worked somewhere I thought fine, I’ll work with this Asian patient, but actually the Asian patient might not wanna work with you. You know, and, and I- I’ve had that. And we found out it was because I’m Asian. Because I may know someone in the masjid. And obviously I’m bound by confidentiality but it’s, it’s the feeling of trust and confidence to do that. So, there’s lots of thoughts I imagine get- er, getting in the way of, of people accessing services basically’

Through this insight into local communities, Suleiman advocated the importance and need for more psychological therapy services to be developed for each local community.

I don’t think the services are, are actually investing the time and resources in developing culturally specific services that are really obvious, ok... They need to
be in the heart of the community. Like a pharmacy ok... They need to be in the heart of St Matthews if that is another area, or the heart of the Polish community, they need to be right in there, ok.

**Yusuf (interpreter) – cultural expert**

Yusuf appeared to be culturally fluid. He felt at home in a variety of contexts and felt comfortable in various cultural settings. Yusuf positioned himself as a cultural expert and felt that this expertise contributed to his positive relationship with the therapist.

Well I think um, to a certain extent the therapist saw me as not only as an interpreter but also somebody to consult on certain cultural issues. There were times when the therapist would actually say something in English and then sort of ask me to reword it with cultural sensitivity

This is reflected in Yusuf’s stone placement (Figure 12), in which he appeared to indicate that he had the closest understanding equally with each of the other triad members.

*Figure 12. Culture Narrative: Yusuf’s positioning of stones*
Ibrahim (client) – cultural awakening

Ibrahim was born in the Azad Kashmir region of Pakistan and came to the UK with his family. Whilst talking about a greater cultural affiliation with his Pakistani community, you got a sense of someone who is quite conflicted in this regard, particular in terms of attitudes held about mental health issues.

In my culture they say... I’ve spoken to a lot of people and they say what, you’ll be okay just don’t stress. You’re stressing a lot a lot of people have told me that and then a lot of people have said go to see the spiritual healer (peer) and this and that but we don’t believe in spiritual healers that’s why I didn’t go. But I...people say you’re putting this pressure on yourself and try, but they don’t understand that these pressures happen by themselves, even if a person doesn’t try they appear.

By the end of the interview you hear an awakened voice emerge in Ibrahim, where he seems to be awakened in terms of knowledge of mental health and takes an enlightened cultural standpoint on this issue.

Before I used to think that you were born with it, that it happens a lot to people from birth, but then I think what if in my life there have been lots of pressures in life. There’s been lots of big tragedies which I don’t want to talk about and what if thinking about this again and again makes a person go crazy. But I can’t say 100%. Different people have different opinions about this. I try with a lot of people. To make myself better I talk to a lot of people and they give me different answers about what the causes could be. Some think you’re born with it and I used to think that you’re born with it but I now after therapy I think what if I put too much pressure on my mind and it happened cause of that.
Discussion

This section aims to draw together and summarise the findings of the research in the context of the existing literature. It will then review the strengths and limitations of the research and highlight implications for clinical practice and areas for further research.

Overview of the current study

The study aimed to explore the narrative accounts given by Pakistani clients, their therapist and the interpreter (the triad) when talking about their experiences of psychological therapy, the roles that they assumed and the relationships that formed.

Two key narrative themes emerged from the data: a Power Narrative and a Culture Narrative.

Summary of findings and previous literature

A key idea that came through in the findings centred around the notion of power in each triad. The first Power Narrative drew out internal and external stories of the tensions that triad members faced during therapy in their struggle to maintain therapeutic control. Foucault (1980) talks about the inseparable relationship between knowledge and power, joined through discourse. Therefore, humans govern and regulate themselves by producing narratives that are “not only structures of meaning but structures of power as well” (Bruner, 1986, p. 144). All participants used this Power Narrative when talking about their experiences, but how this narrative played out in the triads varied.

In Triad One in particular, all three members described feelings of powerlessness in different ways. Haider (client) immediately positioned himself as powerless due to his lack of knowledge and cultural beliefs. Farida (interpreter) and Jane (therapist) also felt powerless when they responded to certain questions, but due to the dynamics of the triad there seemed to be a power struggle between them. None of the members of the triad came across as particularly confident in their understanding of their role. This
almost created a power vacuum in the triad, with members assuming roles and positions of power by default. The importance of power and power dynamics as a key factor in triadic relationship has previously been highlighted by Tribe and Thompson (2009), who suggest that difficulties within triads arise when participants feel disempowered, creating anxieties which affect relationships within the triad.

In line with Foucault’s (1980) conceptualisation of power, it seems that in the triad the issue of who has knowledge is more contested or dispersed; the therapist is de-powered through reliance on the interpreter's language knowledge. As such there appears to be a situation where each member of the triad is a partial knower (the therapist has the mental health knowledge, the interpreter the language and cultural knowledge and the client their own experiential knowledge). The struggle with regards to power dynamics is therefore how the different partial knowledges are combined through a process of co-construction. This notion of each member of the triad as a partial knower and therefore an equal contributor to the therapeutic process and equally responsible for the relationship formed can be considered a relatively new finding of this study, not clearly focused on in previous literature in a triadic therapy context.

Having clear understanding of roles and expectations in therapeutic triads has consistently been mentioned in the previous literature as a key factor in the success of triadic therapies (Engstrom et al., 2010; Miller et al., 2005; Mirdal et al., 2012).

For example, when asked about her role, Farida refers to making the client’s life easier and helping the client to understand. This client-focused view was similarly shared by Jane. However, neither Jane nor Farida thought of their purpose as also being there to support each other, which is reminiscent of a dyadic rather than a triadic or collaborative way of thinking. This finding fits with previous research in which Mirdal et al. (2012) mentions that bonding between only two out of the three members of the triad can severely hinder the therapeutic process, and this is what is reflected in the narrative of Triad One. Accordingly, members of Triad Two emphasised continuously that all three participants got on equally well within the triad and consequently had a more positive collective experience of therapy as reported by each member, lending credence to the findings of Mirdal et al. (2012).
Both therapists positioned themselves as leaders of the triad with aspects of superiority drawn from their professional status. However, in Triad Two this dynamic was more clear and accepted by members of the triad who engaged positively with this structure, whereas in Triad One there seems to be much more ambiguity over leadership and importance of roles. Despite these differences, the effective outcome for the client in both triads was quite similar, in that both felt quite powerless in terms of control over the therapeutic relationship. This ties in with the suggestion of Costa (2010) that clients, merely by virtue of their social and cultural differences, can feel infantilised and powerless in therapy due to the formal dynamics of the triad, and not necessarily through the fault or deliberate actions of therapists and interpreters.

In some cases, as seen in Triad One and previous literature (Tribe, 1999), feelings of powerlessness can occur due to the unfamiliarity of the situation or lack of control over others in the therapeutic space. Jane’s narrative in Triad One is reminiscent of psychodynamic defences described by Kline et al. (1980) and possibly created a sense of infantilisation in Jane, which perhaps led to a projection of her anxieties. As a result, Jane appeared distant from the client, despite stating at the outset that the client’s experience was central to the therapy process.

The role of the interpreter is key to maintaining the balance and harmony of the triadic group (Raval & Smith, 2003). For example, both triads had therapists with a strong sense of leadership and clients who were quite passive and receptive to therapy. However, in Triad One the therapeutic dynamic was affected by the role assumed by the interpreter who was a strong cultural advocate. This ties in with the continuum model proposed by Leanza et al. (2015), where the complexity and ambiguity of the interpreter’s role is acknowledged. In many cases, the success of the triadic therapy will depend on the definition and remit of the interpreter’s role.

Similarly, there is a subtle difference between the approaches of the two interpreters through their Culture Narrative which may have influenced the dynamics of their respective triads. Yusuf positioned himself as a cultural expert who acts as a broker, advising the therapist on a range of cultural issues and sensitivities and using his
knowledge to enhance the therapeutic process. The Culture Narrative can be seen as a process of unpacking the dominant social discourse that may be present in narratives that shape the construction of the client’s story. It seems the interpreter in acting as a cultural broker created a more helpful alternative story. This seemed to contextualise the client’s story and also perhaps emphasise the importance of recognising individuals’ agency and power. Farida, on the other hand, whilst having similar expertise saw herself as a cultural advocate, speaking up for her cultural beliefs and practices and almost attempting to justify cultural practices on behalf of the client. Miller et al. (2005) and Yakushko (2010) identify cultural expertise as helpful in developing understanding of the client. However, it is important to avoid bringing unnecessary cultural or religious baggage into the therapeutic space (Tribe & Raval, 2003).

The background and initial cultural knowledge of both therapists plays a key role in the success of their respective triads. In Triad One, Jane acknowledged that she was very culturally different to the other members of the triad and acknowledged limitations in her cultural knowledge. Conversely, in Triad Two Suleiman was very culturally fluid and identified himself with several different cultures. This was perhaps reflected in the narratives of the respective triads, with Suleiman having to only deal with linguistic barriers whereas Jane was left with too much to overcome, feeling like an outsider within the group. This concurs with previous research by Becher and Wieling (2015) which identified that therapists can feel left out of the therapeutic relationship when there is too much cultural and linguistic unfamiliarity.

Both clients, through their narratives, were found to experience a process of awakening in terms of their knowledge, awareness, and attitudes towards mental health issues. Both Haider and Ibrahim also became more culturally aware, indicating that cultural understanding is a two-way process in a therapeutic alliance. They identified aspects of their culture or social philosophy which they called into question, and mentioned that the therapeutic process had made them more aware of limitations imposed upon them by peers and cultural expectations. The clients appeared to have benefitted both in terms of therapy and also gained significant and useful life insights.
Implications of findings

Clinical Psychology and the wider NHS

The findings of this study can be used to enhance existing BPS guidelines for psychologists working with interpreters in psychological therapy. For example, existing BPS guidelines suggest that therapists should undertake training courses on working with interpreters, the need for which is emphasised by the findings of this study. Furthermore the findings of this research recommend that the delivery of these courses would be enhanced by including specific course material relevant to each particular client cultural group to increase an understanding of linguistic and cultural barriers and help to address them.

In addition, BPS guidelines could be enhanced by acknowledging a greater focus on relationships formed in therapy. This study has shown the importance of relationships in addition to the more traditional notion of roles and responsibilities. Therefore, therapists may benefit from considering the collective expertise of each member of the triad as a partial knower and foster relationships to increase the chances of collaboration during therapy. Given that it was found that each member had an equal contribution to make to the triadic relationship, it is important to focus on relational aspects of the triad as much as the delivery of the therapeutic approach. It may therefore be beneficial for services to find a way to emphasise to each member their importance to the therapeutic relationship and facilitate the development of that relationship from the outset.

The findings can also be used to prepare therapists for possible challenges and suggest ways to overcome them. Additionally, services need to facilitate open discussions and dialogues between therapists and interpreters before and during therapeutic work, to enhance the collaborative relationship.

There is a need for mental health services to make an appraisal of their client base to include cultural issues, and if necessary involve interpreters in the discussion of client support where cultural knowledge of therapists is limited.
The rich narratives produced by this study have given rise to the importance of exploring the meaning that individuals place on their experiences. This narrative approach can help staff involved in therapies to better understand the experiences and cultural standpoints of Pakistani clients and help to develop cultural competence.

In addition to this, the ideas highlighted in this study around narrative co-construction have important clinical implications for the way in which individuals within the triad position themselves and take responsibility for aspects of the therapy process. For example, the therapeutic alliance is relational and not solely based on individual roles; each member brings their own expertise and this forms a collaboration and a collective narrative. It is therefore important that relational aspects are focused on when conducting triadic therapy. The idea of partial expertise amongst members of the triad has particular clinical implications, suggesting that the task for members of the triad is to work out how their partial knowledge is to be combined in order to create effective relationships and a strong therapeutic alliance.

This study has gone some way to highlighting some of the reasons why individuals from Pakistani communities do not come forward with mental health difficulties. Some of the issues identified include: lack of trust, perceived lack of understanding, and educational factors. These issues can be addressed by health professionals in collaboration with these communities.

*Interpreting services*

One of the issues identified by this study is the fact that interpreters can find therapy sessions quite challenging for a number of reasons, most of which can be addressed by better training and the sharing of experiences between interpreters and fellow professionals. An implication of this study could therefore be for interpreting services to facilitate this forum to share experiences in order to better train interpreters and prepare them to take part in therapeutic work. Where possible, such training could be conducted collaboratively with psychological therapy services.
Interpreting services could also be encouraged to offer additional support for interpreters, in terms of their professional translating services and also in dealing with complex and sensitive psychological work. For example, providing a forum for interpreters to seek their own psychological support if needed.

**Pakistani Community**

Community leaders from Pakistani backgrounds could benefit from insights provided by the current research, particularly as they are identified as a first port of call when psychological issues arise in the community.

The positive experiences of both clients interviewed could be used to provide good publicity for access to mental health services when devising awareness campaigns in local settings.

**Strengths and limitations of current study**

This study raises awareness of several areas where triadic relationships can have an impact on psychological therapy. These factors range from positive impacts such as increased cultural understanding and access to therapy for clients with linguistic barriers, to negative impacts such as non-collaborative therapeutic relationships, role confusion, and general misunderstandings. Ultimately, it is important that many of these factors in triadic therapy have been highlighted by the current study in a rich narrative form, with attempts made to explain their impacts.

The study offers a unique perspective due to its use of narrative analysis and its exploration of complete triads. The rich narrative form of analysis used has enabled voices to be heard which were under-represented in previous research. Given that as humans we naturally think and report our experiences in narrative form, the study allowed voices and stories of the experience of triadic therapy to be captured and analysed. This is very useful for future consideration into service improvement as well as other social and psychological reflections.
A positive aspect of using a narrative analysis method was the opportunity to engage deeply with the participant’s stories and gain an in-depth understanding of the meanings behind responses to interview questions. Qualitative methodologies can be criticised somewhat for researcher bias, however the narrative voice-centred relational method acknowledges and encourages the researcher’s inclusion and involvement in shaping the narrative accounts, and thus the analysis does not aim to be objective. Consequently, its strengths lie in gaining levels and layers of understanding towards the subject material. This stresses the need for future research into the experience of triads, in order to gain deeper insights into these narrative accounts.

The researcher’s multi-lingual skills enabled her to approach and interview participants in their own language and furthermore adapt wording in accordance with dialects within the language. This provided a much more natural and authentic access to participants for whom English was not a first language, as the researcher was able to consistently speak to all participants one-to-one without the need for an interpreter. The researcher’s own British Pakistani background further enabled her to understand the multitude of references and terminology used by participants from all cultural backgrounds.

As a researcher, being a member of the Pakistani Kashmiri community presents advantages and disadvantages especially when this is shared with participants in the research. Familiarity with the participants and being from the same cultural background and ethnicity may have allowed the researcher to gain insider status. According to Merriam et al. (2001) ‘mutually perceived homogeneity can create a sense of community, which further enhances trust and openness throughout the research process’.

However, it is important to note that conversely this same familiarity may have prohibited disclosure by respondents. For example, existing literature shows that interpreters from a similar background may carry cultural, political or religious baggage that hampers client disclosure of sensitive personal views and information (Tribe & Raval, 2003). Similarly, clients may worry that the interpreter could be judgemental of their feelings and be concerned at the level of professionalism and confidentiality.
These factors affecting interpreters from a similar cultural background may also affect a researcher in a comparable position.

Furthermore, the fact that the researcher was female and all the participants were male could have had an unforeseen impact, and differing cultural roles and perceptions of gender need to be acknowledged. From a Pakistani cultural perspective, it is possible that some participants may have withheld certain information from a female that they would have been more willing to share with a male (The Change Institute, 2009).

It is important to maintain awareness of the role of the researcher in the co-construction of narratives. Being part of the same community may have influenced the researcher’s own subjectivity, including the framework within which the researcher saw participants. This is an important acknowledgement, as epistemologically the researcher has taken the standpoint that all the narratives shared in the research are interdependent and collaborative, therefore the researcher’s own narrative and cultural views will inevitably influence the accounts.

As the Interviews were transcribed by the researcher, with interviews conducted in Pakistani languages further translated into English, the issues around this require addressing. There were many advantages and disadvantages with the researchers close involvement in this process. Whilst being very time-consuming, transcribing the interviews allowed the researcher to become familiar with the narrative accounts of participants and also gain insight into the process of interviewing participants and allow subsequent interviews to be tailored accordingly. However the added dimension of having to transcribe the interviews in Pakistani languages into the English language comes with its own challenges. Whilst also sharing advantages with the transcribing process of the other transcripts, it may reduce the reliability of the translations generated. To address this, the researcher made attempts to increase the reliability of the translated narrative by getting an additional translator to also be involved in the translation process. The subsequent transcripts were also verified for their accuracy by an independent transcription service. In hindsight, to ensure further accuracy and increase the reliability of the translations, the original transcripts could have been
translated by an independent company and also back translated to validate the interpretation made.

Many of the limitations of this study centred on recruitment difficulties and the various challenges in finding eligible participants. It needs to be acknowledged that the results are not generalisable and other triadic groups may well construct different narratives and report different experiences of therapy. An example of this is the fact that both clients were male, giving rise to potential gender differences, particularly as within Pakistani culture there are traditionally aspects of gender difference in terms of roles and identities within communities.

In one triad, all participants were Muslim, and in the other triad, all participants were also Muslim with the exception of the therapist, Jane, who was not. This may have been a factor in determining relationships and cultural understanding, but the present study did not have the time or resources to look into how religious beliefs, in addition to culture, shaped the narratives of participants in detail. This limitation highlights the inherent difficulty in defining Pakistani culture, and the problematic issues arising when considering Pakistani’s as a homogenous community with a common culture. Within the Pakistani community there are many religions, cultural practices, and differences in languages, all of which define members of the communities and shape their narratives. A recommendation for further research would be to explore these differences within the sub-sections of Pakistani communities in order to inform a more tailored approach to therapy in future.

Despite the best efforts of the researcher to encourage open dialogue and disclosure during interviews, there are factors which may have affected the responses of the participants. For example, therapists were recruited via IAPT services and interviewed by a trainee clinical psychologist about their professional work, and therefore they may have felt that they were limited in what they could comfortably discuss. Similarly, clients and interpreters interviewed by a trainee psychologist may have felt that they were back in a therapeutic setting due to the similarity with their experience of a therapeutic situation. This may have limited their responses, particularly if the trainee psychologist represented a figure of authority.
Issues with the use of the ‘i-poem’ were identified when going through the readings of the transcripts for the two clients. The Urdu and Mirpuri languages do differentiate between ‘I’ and ‘we’; these are separate notions in the languages, therefore the use of i-poems was not deemed to be an issue in advance. However, once the interviews had been transcribed, it was observed that the Pakistani clients often used the word ‘we’ when talking about the self. This could be reflective of the collectivistic nature of the culture and also the fact that when speaking formally, the word ‘I’ is sometimes changed to ‘hum’ (we) as this is deemed a more formal or respectful usage. This, therefore, presented a challenge to using the i-poem for the client transcripts. The i-poem assumes the notion of ‘I’ in the English language and the western cultural notion of self. Upon examination of the client transcripts, it was decided by the researcher that the viability of using an i-poem was compromised in the clients’ case because of the reasons mentioned, especially due to the ambiguity of the word’s usage in practice. In hindsight, this requires attention in future research whereby a hybrid I/We-poem could be devised to try and compensate for this difference, and focus on more collaborative or collectivistic statements across all transcripts from all participants.

Finally, due to the use of quotes and narrative accounts in the current research, there is a possibility that members of each triad will be able to recognise their responses despite anonymisation, and by extrapolation learn the responses of the other two members of their triad. This is a limitation of exploring the triad as a whole, which participants were made aware of and could have had an impact on responses shared during interviews.

Recommendations for future research

This study has numerous implications for future research, and its limitations highlight the need for more research in this area. The experiences of triads and the triadic therapeutic alliance is an under-researched field, and future studies are required to gain more insights into triadic experiences. Specifically, the study highlighted several areas of importance in triadic therapy including power dynamics, centrality of relationships and the idea of partial knowledge and expertise. To develop this, more relational
research is needed that takes the triad as the unit of study rather than researching individual members of the triad in isolation.

Furthermore, given the limited amount of research in this area, a further recommendation would be to explore these ideas within different contexts beyond IAPT and also different communities and sub-sections within communities in order to generate more transferrable results and themes. These could be used to inform a more tailored approach to therapy in the future.

**Conclusion**

In conclusion, the narrative experiences of Pakistani clients, their therapists and interpreters show that a collaborative, triadic form of therapy is incredibly complex and requires a delicately balanced set of attitudes and expectations to be present within each member of the triad. It is therefore vitally important that this therapeutic alliance is entered into with each member being clearly aware of their roles and responsibilities within the triad. In particular, attitudes towards power, control and culture are predominant themes upon which the therapeutic alliance is based and balanced. The notion of power dynamics, and the idea of each triad member as a partial knower or partial expert is a relatively new finding of this study. Furthermore, another new implication of this study is the emphasis on the centrality of relationships to the therapeutic alliance. Ultimately, it is evident that experiences of clients, therapists and interpreters vary greatly, and that a great deal of further research is necessary in order to recommend best practice to ensure consistently positive therapeutic experiences in future.
References


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Chapter Three: Critical Appraisal
Critical Appraisal

The following is a reflection on my research journey. This was based on personal notes taken during the research process, and thoughts that I had recorded in my reflective journal which I kept and updated throughout. A chronology of the research process can be found in Appendix Q.

Development and choice of research idea

At the start of training I was given the opportunity to choose my own research idea. At this point I felt compelled to choose a topic that was personally important and held significant meaning to me. I also saw this as an opportunity to express myself, in terms of exploring subjects that formed the basis of my reason to enter the psychological profession in the first instance.

Coming from a Pakistani background, I already had a strong personal interest in the subject matter chosen for the current research study. Having often translated for and on behalf of a parent who speaks little English, I had first-hand experiences of the barriers and communication difficulties that people with limited English proficiency encounter during interactions with healthcare professionals. Furthermore in a professional role as an assistant psychologist I have experienced the misunderstanding that can arise from situations where a client speaks little English and how this can inaccurately portray information. I remember a particular occasion where the mental health narrative shared by the team was that a Pakistani father was very punitive and critical towards his son’s educational abilities, based on the language he had been using. Due to lack of good English, the father had been telling the team that his son was “dumb” in “science”, and kept repeating “no good” as a description of his school work. However, upon my involvement as a makeshift interpreter for my clinical psychologist supervisor, I was able to converse with the father in his native language and understand that he had actually been trying to explain to the team that his son did not excel in sciences as much as he showed aptitude and creativity in arts, and that he would recommend him to pursue practical or creative arts as a preference to traditionally taught subjects. This was
a huge eye-opener for me personally, as I recognised the magnitude of what could have been lost in translation, and this experience has stuck with me throughout training.

Alongside this, I am also aware that linguistic barriers do not form the only reason for diminished access or poor quality of experience for Pakistani clients in mental health therapies. In fact, cultural and societal barriers centred around attitudes to mental health issues can be just as limiting. I observed this first hand when witnessing the experiences of a male family member with bipolar disorder, which highlighted social taboos and stigmas towards mental health issues within the Pakistani community. The manner in which first-generation community elders responded to his experiences cemented my view to undertake a project that would allow me to explore cultural influences on psychological therapy.

My motivation to make a positive impact in this field is boosted by my personal ability to speak several languages and dialects relevant to Pakistani communities. This, coupled with my professional background allowed me to pursue this research topic with the confidence that I can make a meaningful contribution to the existing body of research.

Specifically, as my interest in this field started very early on I had already gauged existing research available in this area in planning for my first year critical literature review assignment and decided a scope for this present research well in advance. I was surprised by the lack of research on triads within a therapeutic setting, particularly as triadic therapy is so common for people with diminished English language skills due to the need for an interpreter to be present. This early development helped to shape my current project.

As a trainee clinical psychologist, I also felt that this research provided an opportunity for me to develop my professional skills and personal understanding of the experiences of clients, interpreters and therapists in a triadic setting. In my future practice I may require the services of an interpreter to engage with a client from a different linguistic and cultural background, and I felt this research would serve as good preparation to meet the unique challenges of such a situation.
I was allocated a supervisor for this research, and during our initial meetings I shared my ideas and interests with him. It so happened that my supervisor had another trainee who was also undertaking some research looking at the specific experiences of interpreters, and therefore was already quite interested in this field. Together, we decided that it would be interesting and beneficial to explore the experiences of the client, therapist, and interpreter triad as a whole.

Along with my supervisor, we discussed many different ideas and methodologies. I was personally familiar with IPA having used it before, and was comfortable with that approach. However, the more we spoke about the interests of the project being centred around narrative accounts and cultural influences, the more IPA did not seem to fit. My supervisor mentioned the narrative approach, which was a less familiar method for me. I had previously utilised the narrative therapy approach in my work as a trainee clinical psychologist but not in a research context; I did like the approach and had found it useful in therapy. Specifically, my supervisor had just marked a thesis which had used the narrative voice-centred method of analysis, which we discussed and I agreed that it seemed fascinating and relevant to my own preferred choice of subject. I read up on this method, and the more I read the more it seemed to fit with the aims of my project and the aspects that I wanted to focus on.

**Gaining ethical approval**

Having decided the overall topic, I went on to develop a research proposal. The next challenge was to apply for ethical approval. Having worked as a Clinical Studies Officer (CSO) in a previous role where part of my job was to complete and apply for governance approval, this process was not as daunting as expected. I had completed some university-led training, which was a useful reminder of all aspects of the procedure. I subsequently applied for ethical approval and managed to obtain approval quite quickly in January 2015.

Further to this, I had to gain governance approval from different research and development (R&D) trusts to which I was applying to conduct my research. Initially
this was started in one NHS site, which went relatively smoothly albeit with delays in providing responses and approval due to staff absence in that particular trust. I began to realise the potential for delays based on my reliance on cooperation from multiple fellow professionals, and the need for me to be assertive yet understanding towards their own time pressures.

As I applied for approval from the initial site and encountered delays, it had a knock-on effect on my subsequent recruitment which proved difficult from that trust. I then found I had to widen my reach to other trusts, but had to start at the approval stage with each one. This, and the current situation of many NHS R&D departments being short-staffed, caused delays to my recruitment process and in hindsight I would have applied for initial approval from multiple NHS sites simultaneously at the outset.

**Recruitment**

Prior to receiving ethical approval I contacted IAPT services to determine feasibility of the study and had preliminary conversations with some of the managers to gauge interest. Through my previous experience as a CSO I hoped taking a top-down approach would help make recruitment to services easier. I was conscious about my role as a trainee clinical psychologist and wondered if the service would be deterred to engage in my research project, particularly due to potential professional sensitivities between IAPT and clinical psychology mentioned by other trainees who had worked in IAPT. However, the overwhelming response from IAPT services was positive, they showed interest in my topic which in turn motivated me and encouraged me in my research.

Having obtained ethical approval early, I was keen to start recruiting as soon as possible. The service manager at the initial site I approached was very interested in my project and introduced me to other members of the team and agreed to send information to therapists in the service. However, despite gaining approval from the service I started to find it difficult to recruit. I did not very many responses from therapists, and my research depended on getting all three members of a triad on board. So the therapists were a gateway to other members of the triad, and without their response I was not even
able to find out whether the recruitment of an entire triad was possible. I attended several meetings and sent numerous emails, however I was told that most South Asian clients are allocated to South Asian therapists who are able to speak the languages. This was interesting, and made me reflect on whether this technical aspect limits client choice, and whether South Asian clients are prevented from choosing which therapists they want to see based on the fact that they might need an interpreter with their preferred therapist. I had initially chosen this trust as it was located in an area where there was a large South Asian population, but due to this issue of allocating South Asian clients to South Asian therapists I was unable to find relevant recruitment and moved on further afield.

In one case, I was able to gain access to a report of all South Asian clients seen by IAPT therapists in a particular trust, and identified some eligible triads. However, I struggled to get therapists on board, with therapists citing reasons such as lack of time and resources due to staff shortages or service restructuring as to why they were unable to participate in the project. I gained an understanding of how challenged and strained services are regarding resources and priorities, but must admit that the lack of progress was quite frustrating. Upon reflection, I would estimate a very different timeframe allocated for recruitment in addition to the already generous time frame I had given myself.

As delays occurred over the recruitment process, a lot of my tasks transferred from the main research to chasing up responses from the trust, and as a result I began to consider whether I would need to further widen my outreach for recruitment. This experience caused me to completely re-evaluate the way in which I would structure and time-manage a recruitment process in future research opportunities.

I approached another trust, and similarly found it difficult to identify participants. After some time and moving to yet another trust, I managed to find eligible triads. In all, it took a whole year to recruit two eligible triads who were ready, willing and able to take part in my research. Although my initial aim was to recruit three complete triads, after discussing with my supervisor and reflecting on my narrative analysis method and
understanding the depth of the narratives that I obtained, I felt that two triads were appropriate for my project.

**Interviewing participants**

Following consultations with my supervisor, I developed an interview guide for participants. When devising suitable questions, I considered doing three separate interview guides, tailored for clients, interpreters, and therapists. This did not seem appropriate, as comparing and contrasting the narrative accounts at a later stage would be difficult if each participant had a unique line of questioning. Therefore, to maintain consistency I had to devise interview questions that were relevant and specific enough to keep my research meaningful, but flexible enough to accommodate the differing responses of each participant. The questions had to be appropriate for clients, therapists, and interpreters and therefore took a lot of thought and consideration. I chose to frame most of my questions in the context of the triadic relationship, and this helped to keep the questioning relevant to the participants and my research. A further challenge was to take into account how the questions needed to be framed in the various languages and dialects that were to be used, and for this purpose I conducted some pilot interviews for practice with another multi-lingual trainee clinical psychologist.

The first time I did an interview I was very nervous. It was hard to switch from the mode of a therapist to a researcher. I constantly reminded myself not to give reflective responses, summaries or formulate the participants’ accounts and experiences. I used supervision to reflect on this and wrote up reflective notes after each interview to keep tight control over my interview technique and remain grounded in participants’ accounts.

Despite being fluent in several Pakistani languages, I felt an additional pressure in the client interviews as I realised that I had never conducted interviews outside the English medium. I was quite nervous about these, and was conscious of using lots of substituted English words when speaking in Pakistani languages. To mitigate this, I tried to brush up on my language skills by speaking in community languages more among family and
friends, and also tried to increase my formal vocabulary rather than use slang words or English substitutes.

The interview process itself proved to be very refreshing and enlightening for me, both professionally and personally. I thoroughly enjoyed listening to the stories shared by the participants and appreciated the strength it took for them to share them with me. Some stories drew me in more, for example I was very fascinated by the narratives of the Pakistani clients and, reflecting on my mother’s healthcare experiences, felt I could empathise with their sense of powerlessness in the triad. However, on further reflection I also found myself empathising with the therapist and the interpreter at different times, having been in those roles myself at various points in my life. The challenges faced by different members of the triad often felt familiar and relatable, which helped me to embed myself in the narratives when I came to analyse them later.

The stories that some of the clients shared brought about several different emotions in me. I found myself feeling sad at how lost they were getting in the triad, and how they were completely out of their depth in terms of the group dynamics within the triad. Having heard the therapist and interpreter stories first further brought this point home. I used my supervision sessions to reflect on this and the feelings that it evoked in me. Both clients spoke about a sense of debt to the therapist and interpreter for their support - this was also saddening and at times I felt like I wanted to reassure them that they were just as worthy as other members of the triad and that accessing therapy was their right. It was therefore satisfying and encouraging to hear them subsequently go through a sense of enlightenment and express their profound satisfaction with the overall outcomes of their therapy. I felt slightly embarrassed when at the end of an interview one of the clients repeatedly thanked me for allowing him to participate in the research. I believe that the small changes in attitudes that became evident through this research are key to mutual understanding of these situations and overall improvement of future services and engagement.

Hearing the therapists’ stories was also very interesting, particularly their narratives of working in a triad, which I have not yet had the opportunity to do in my own practice. I empathised with some of the challenges they reported, as they matched some of my
own anxieties about going into a triadic session. It enabled me to reflect on my own future as a clinical psychologist and how I would like to develop my professional skills and practices.

I felt very grateful to all the participants for sharing their stories with me. I have always been interested and valued qualitative research and hearing people’s experiences, and this project has cemented my view of the importance of exploring and sharing narratives.

Transcribing

I had initially thought of using a transcription service to transcribe the interviews, but later decided to do it myself given small number of participants. I also saw it as an opportunity to get familiar with the data. Looking back, I am pleased that I engaged with this portion of the workload wholeheartedly, as the repeated listening helped me to immerse myself in the narratives, appreciate the expression within the voices and not just the written words. This also helped with later analysis.

The Pakistani client interviews took the most thought and effort to transcribe, as I had to transcribe them in original script and then translate them into English for use in this research. Therefore, the process of transcribing took longer than I had anticipated, and I also had to be careful about the translation process, that it stayed close to the original spoken words and faithful to the narrative account. In the case of the Mirpuri dialect used by one of the clients, it is not even a written language and had to be transcribed in Urdu script prior to translation, which added time to the process.

Listening to the interviews also provided me with an opportunity to reflect on, and improve, my interview technique and identify areas where I needed to concentrate on being a researcher rather than a therapist. It was also interesting to observe how my own vocal replies during the interview mirrored or responded to the information from the participants, showing how I was affected by emotional or unexpected material.
Analysis

My experience of the analysis process varied. At times I found myself frustrated by the lack of direction provided by the narrative approach and did not feel confident in the process. In time, I learned to appreciate the autonomy that narrative analysis provided me as a researcher, but was aware of the amount of subjectivity that I would have to bring to the narrative myself. I found it helpful to read the chapter by Mauthner and Doucet (1998) in the book ‘Feminist Dilemmas in Qualitative Research’. Speaking to my supervisor helped me to overcome feelings of incompetence as a researcher using an unfamiliar method of analysis.

When starting to analyse, I listened back to each interview several times before conducting the four readings suggested by Brown and Gilligan (1992) in their narrative voice-centred relational method. In the first reading, I read through the transcript paying close attention to the stories and plots that were being told by respondents. I had the opportunity to recognise the narratives that each member of the triad brought, and appreciate how this formed an overall narrative for the triad. It was very satisfying to be able to finally see my analysis method working and this gave me more confidence in using the method. This reading also involved another process whereby I was required to pay attention to my own responses and emotions on what I was hearing or reading. This was quite a liberating experience and really helped me to reflect on what I was bringing with me to the research in terms of my own cultural beliefs and subjectivity.

Reading two, the i-poem, was also very interesting and a completely new research experience for me. When described in theory, I admit to feeling less than convinced about this technique and its effectiveness in drawing out meaningful analysis. However, as I went through each transcript to highlight all the direct first person statements from the text and noted these in the order that they occurred, it formed a perspective that complemented and enhanced the established themes. It also delivered a characterisation of each participant and helped me to understand what each member felt to be important to them, in a way that I may not have appreciated through a conventional reading. Due to the limitations of language, I could not write out an i-poem for the clients as it was not always clear in translation what would have been a genuine “I” statement and what
was a necessity of the translation process. I feel disappointed that I could not capture this perspective for all participants, as it would have provided further insight into the client narrative.

In reading three, I paid close attention to how participants spoke about the relationships and interactions they had with other members of the triad, as well as broader networks in which they were located, such as their community. Each identified relationship that clients spoke about was highlighted and colour coded, and followed through the transcripts which was valuable in creating a narrative of interactive relationships.

The fourth reading focused on structured relationships and dominant narratives, and was required to prioritise the important themes that I would deal with as the main portion of my findings. I looked for overarching concepts which linked the small interactions in the transcript to the bigger picture, including cultural contexts and wider societal discourses in which the narrative was embedded. This step was important for me to keep in mind the different contexts within which each participant presented their narratives, including influences such as belief systems, professional constraints, social pressures, and past experiences.

In analysing the narratives I found myself thinking a lot about ethical considerations, especially whether participants would be offended by how I had analysed their accounts and drawn conclusions. Reflecting on this with my supervisor, I realised that this was a lesson that I needed to learn professionally in order to deal with difficult choices and challenging material that I would be subjected to now and in my future experiences. I also learned that I needed to remain true to the research and that emotional responses to the accounts could not influence the analysis process.

The end of the analysis process was a relief and an empowering experience. I feel that I personally overcame many hurdles and in the process, developed better skills of analysis and self-management.
**Write-up**

Putting my notes, thoughts, and findings into a structured write-up was a very daunting experience. Even the basic grammar of writing became a challenge as depending on how recently I had made a particular note, I found myself jumping from past to present tenses within the same section of work. Due to the qualitative nature of my analysis, I had produced a large body of work which needed to be expressed in a condensed form within the constraints of the word count. This was particularly difficult and hard choices needed to be made, upon reflection and in consultation with my supervisor, regarding important quotes or points that needed to be omitted from the final draft due to limited space.

The large amount of data gathered, and the long-winded nature of the narrative analysis, meant that I felt particularly daunted by how I would structure and present my findings in a coherent and meaningful way. The lack of research on triads also meant that I was unable to draw inspiration from any precedents set in this respect. Eventually, I followed the guidance of Mauthner and Doucet (1998) and presented the results as two case studies.

**Dissemination**

Along with my supervisor, I have identified some conferences that may be useful forums for me to present this research. I also plan to present my findings at a forthcoming trainee research conference. To begin with, I will submit my completed thesis to the University of Leicester, whereupon an electronic version will be available through the university e-library. I plan to prepare a paper for publication in a peer-reviewed journal, and further to this I will also produce a summary for participants and services.

Appendices
Appendix A: Author Guidelines

Journal: Psychology and Psychotherapy: Theory, Research and Practice

Psychology and Psychotherapy: Theory Research and Practice (formerly The British Journal of Medical Psychology) is an international scientific journal with a focus on the psychological aspects of mental health difficulties and well-being; and psychological problems and their psychological treatments. We welcome submissions from mental health professionals and researchers from all relevant professional backgrounds. The Journal welcomes submissions of original high quality empirical research and rigorous theoretical papers of any theoretical provenance provided they have a bearing upon vulnerability to, adjustment to, assessment of, and recovery (assisted or otherwise) from psychological disorders. Submission of systematic reviews and other research reports which support evidence-based practice are also welcomed, as are relevant high quality analogue studies. The Journal thus aims to promote theoretical and research developments in the understanding of cognitive and emotional factors in psychological disorders, interpersonal attitudes, behaviour and relationships, and psychological therapies (including both process and outcome research) where mental health is concerned. Clinical or case studies will not normally be considered except where they illustrate particularly unusual forms of psychopathology or innovative forms of therapy and meet scientific criteria through appropriate use of single case experimental designs.

All papers published in Psychology and Psychotherapy: Theory, Research and Practice are eligible for Panel A: Psychology, Psychiatry and Neuroscience in the Research Excellence Framework (REF).

1. Circulation
The circulation of the Journal is worldwide. Papers are invited and encouraged from authors throughout the world.

2. Length
All articles submitted to PAPT must adhere to the stated word limit for the particular article type. The journal operates a policy of returning any papers that are over this
word limit to the authors. The word limit does not include the abstract, reference list, figures and tables. Appendices however are included in the word limit. The Editors retain discretion to publish papers beyond this length in cases where the clear and concise expression of the scientific content requires greater length (e.g., a new theory or a new method). The authors should contact the Editors first in such a case.

Word limits for specific article types are as follows:
- Research articles: 5000 words
- Qualitative papers: 6000 words
- Review papers: 6000 words
- Special Issue papers: 5000 words

3. Brief reports
These should be limited to 1000 words and may include research studies and theoretical, critical or review comments whose essential contribution can be made briefly. A summary of not more than 50 words should be provided.

4. Submission and reviewing
All manuscripts must be submitted via Editorial Manager. The Journal operates a policy of anonymous (double blind) peer review. We also operate a triage process in which submissions that are out of scope or otherwise inappropriate will be rejected by the editors without external peer review to avoid unnecessary delays. Before submitting, please read the terms and conditions of submission and the declaration of competing interests. You may also like to use the Submission Checklist to help you prepare your paper.

5. Manuscript requirements
- Contributions must be typed in double spacing with wide margins. All sheets must be numbered.
- Manuscripts should be preceded by a title page which includes a full list of authors and their affiliations, as well as the corresponding author's contact details. A template can be downloaded here.
• The main document must be anonymous. Please do not mention the authors’ names or affiliations (including in the Method section) and refer to any previous work in the third person.

• Tables should be typed in double spacing, each on a separate page with a self-explanatory title. Tables should be comprehensible without reference to the text. They should be placed at the end of the manuscript but they must be mentioned in the text.

• Figures can be included at the end of the document or attached as separate files, carefully labelled in initial capital/lower case lettering with symbols in a form consistent with text use. Unnecessary background patterns, lines and shading should be avoided. Captions should be listed on a separate sheet. The resolution of digital images must be at least 300 dpi. All figures must be mentioned in the text.

• For articles containing original scientific research, a structured abstract of up to 250 words should be included with the headings: Objectives, Design, Methods, Results, Conclusions. Review articles should use these headings: Purpose, Methods, Results, Conclusions.

• All Articles must include Practitioner Points – these are 2-4 bullet points, in addition to the abstract, with the heading ‘Practitioner Points’. These should briefly and clearly outline the relevance of your research to professional practice.

• For reference citations, please use APA style. Particular care should be taken to ensure that references are accurate and complete. Give all journal titles in full and provide DOI numbers where possible for journal articles.

• SI units must be used for all measurements, rounded off to practical values if appropriate, with the imperial equivalent in parentheses.

• In normal circumstances, effect size should be incorporated.

• Authors are requested to avoid the use of sexist language.

• Authors are responsible for acquiring written permission to publish lengthy quotations, illustrations, etc. for which they do not own copyright.

• Manuscripts describing clinical trials must be submitted in accordance with the CONSORT statement on reporting randomised controlled trials (http://www.consort-statement.org).

• Manuscripts describing systematic reviews and meta-analyses must be submitted in accordance with the PRISMA statement on reporting systematic reviews and meta-analyses (http://www.prisma-statement.org).
For guidelines on editorial style, please consult the APA Publication Manual published by the American Psychological Association.

6. Multiple or Linked submissions
Authors considering submitting two or more linked submissions should discuss this with the Editors in the first instance.

7. Supporting Information
PAPT is happy to accept articles with supporting information supplied for online only publication. This may include appendices, supplementary figures, sound files, videoclips etc. These will be posted on Wiley Online Library with the article. The print version will have a note indicating that extra material is available online. Please indicate clearly on submission which material is for online only publication. Please note that extra online only material is published as supplied by the author in the same file format and is not copyedited or typeset. Further information about this service can be found at http://authorservices.wiley.com/bauthor/suppmat.asp

8. Copyright and licenses
If your paper is accepted, the author identified as the formal corresponding author for the paper will receive an email prompting them to login into Author Services, where via the Wiley Author Licensing Service (WALS) they will be able to complete the license agreement on behalf of all authors on the paper.

For authors signing the copyright transfer agreement
If the OnlineOpen option is not selected the corresponding author will be presented with the copyright transfer agreement (CTA) to sign. The terms and conditions of the CTA can be previewed in the samples associated with the Copyright FAQs.

For authors choosing OnlineOpen
If the OnlineOpen option is selected the corresponding author will have a choice of the following Creative Commons License Open Access Agreements (OAA):
- Creative Commons Attribution Non-Commercial License OAA
- Creative Commons Attribution Non-Commercial -NoDerivs License OAA
To preview the terms and conditions of these open access agreements please visit the Copyright FAQs and you may also like to visit the Wiley Open Access and Copyright Licence page.

If you select the OnlineOpen option and your research is funded by The Wellcome Trust and members of the Research Councils UK (RCUK) or Austrian Science Fund (FWF) you will be given the opportunity to publish your article under a CC-BY license supporting you in complying with your Funder requirements. For more information on this policy and the Journal’s compliant self-archiving policy please visit our Funder Policy page.

9. Colour illustrations
Colour illustrations can be accepted for publication online. These would be reproduced in greyscale in the print version. If authors would like these figures to be reproduced in colour in print at their expense they should request this by completing a Colour Work Agreement form upon acceptance of the paper. A copy of the Colour Work Agreement form can be downloaded here.

10. Pre-submission English-language editing
Authors for whom English is a second language may choose to have their manuscript professionally edited before submission to improve the English. A list of independent suppliers of editing services can be found at http://authorservices.wiley.com/bauthor/english_language.asp. All services are paid for and arranged by the author, and use of one of these services does not guarantee acceptance or preference for publication.

11. OnlineOpen
OnlineOpen is available to authors of primary research articles who wish to make their article available to non-subscribers on publication, or whose funding agency requires grantees to archive the final version of their article. With OnlineOpen, the author, the author's funding agency, or the author's institution pays a fee to ensure that the article is made available to non-subscribers upon publication via Wiley Online Library, as well as deposited in the funding agency's preferred archive. For the full list of terms and conditions, see http://wileyonlinelibrary.com/onlineopen#OnlineOpen_Terms
Any authors wishing to send their paper OnlineOpen will be required to complete the payment form available from our website at:

https://onlinelibrary.wiley.com/onlineOpenOrder

Prior to acceptance there is no requirement to inform an Editorial Office that you intend to publish your paper OnlineOpen if you do not wish to. All OnlineOpen articles are treated in the same way as any other article. They go through the journal's standard peer-review process and will be accepted or rejected based on their own merit.

12. Author Services

Author Services enables authors to track their article – once it has been accepted – through the production process to publication online and in print. Authors can check the status of their articles online and choose to receive automated e-mails at key stages of production. The author will receive an e-mail with a unique link that enables them to register and have their article automatically added to the system. Please ensure that a complete e-mail address is provided when submitting the manuscript. Visit http://authorservices.wiley.com/bauthor/ for more details on online production tracking and for a wealth of resources including FAQs and tips on article preparation, submission and more.

13. The Later Stages

The corresponding author will receive an email alert containing a link to a web site. A working e-mail address must therefore be provided for the corresponding author. The proof can be downloaded as a PDF (portable document format) file from this site. Acrobat Reader will be required in order to read this file. This software can be downloaded (free of charge) from the following web site:

http://www.adobe.com/products/acrobat/readstep2.html. This will enable the file to be opened, read on screen and annotated direct in the PDF. Corrections can also be supplied by hard copy if preferred. Further instructions will be sent with the proof. Hard copy proofs will be posted if no e-mail address is available. Excessive changes made by the author in the proofs, excluding typesetting errors, will be charged separately.
14. Early View
Psychology and Psychotherapy is covered by the Early View service on Wiley Online Library. Early View articles are complete full-text articles published online in advance of their publication in a printed issue. Articles are therefore available as soon as they are ready, rather than having to wait for the next scheduled print issue. Early View articles are complete and final. They have been fully reviewed, revised and edited for publication, and the authors’ final corrections have been incorporated. Because they are in final form, no changes can be made after online publication. The nature of Early View articles means that they do not yet have volume, issue or page numbers, so they cannot be cited in the traditional way. They are cited using their Digital Object Identifier (DOI) with no volume and issue or pagination information. E.g., Jones, A.B. (2010). Human rights Issues. Human Rights Journal. Advance online publication. doi:10.1111/j.1467-9299.2010.00300.x
### Appendix B: Search results

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**Total Number of articles**: 2267  
**Total Number of articles with duplicates removed**: 987  
**Total number of relevant articles**: 10  
**Total included in meta-synthesis following quality appraisal**: 9
Appendix C: Epistemological position of the researcher

The researcher took a social constructionist standpoint in the current paper. Social constructionism views knowledge as a shared experience; individuals can construct knowledge from their surroundings and share society’s knowledge, using this collective knowledge to build and express narratives (Owen, 1995). Therefore, individuals expressing vocal narratives do so within a variety of contexts which cannot be expressed outside the various social, cultural, linguistic and historical contexts shared universally by all human life (Liampittong & Ezzy, 2005).

It seemed relevant to the research aims to adopt a social constructionist standpoint, as it focuses on how shared understandings and narratives are constructed (Harper 2012). Social constructionism acknowledges that knowledge, accounts, and narratives are interlinked across societies, cultures, and history – this made sense in dealing with the various backgrounds and standpoints of the members of the triad. Furthermore, key to social constructionism is the use of language, and how accounts are not an insight into an individual’s direct thoughts but rather serve a wider range of social and personal purposes (Harper, 2012; Gergen, 1994).

In adopting this view the researcher was able to understand and focus on how individual and collective narratives of the triad were constructed, influenced and embedded within a social and cultural context. Thus the analysis recognised that the experiences of the participants were interrelated not only within the triad, but to larger external influences and dynamics.

It was useful for the researcher to view the triads through this prism, to appreciate the complex interrelatedness of the resulting narratives. This acknowledges the influence of the researcher on the interviews and research in general, and how the researcher is embedded in the constructed narrative. The social constructionist standpoint enabled the researcher to acknowledge the contribution of personal narratives to the stories formed, as social constructionism emphasises the collaborative, shared narrative that is generated upon any interaction. It is useful, from an epistemological point of view, to
therefore contextualise the findings of the study as an account, rather than an absolute or universal reality.

References


Appendix D: Ethical approval letters

Health Research Authority
NRES Committee East Midlands - Leicester
The Old Chapel
Royal Standard Place
Nottingham
NG3 6FS
Tel: 0115 833 8406

<table>
<thead>
<tr>
<th>Study title:</th>
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<td>IRAS project ID:</td>
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Thank you for your letter of , responding to the Committee’s request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this favourable opinion letter. The expectation is that this information will be published for all studies that receive an ethical opinion but should you wish to provide a substitute contact point, wish to make a request to defer, or require further information, please contact the REC Manager, Ellen Swainston, nrescommittee.eastmidlands-leicester@nhs.net. Under very limited circumstances (e.g. for student research which has received an unfavourable opinion), it may be possible to grant an exemption to the publication of the study.

Confirmation of ethical opinion
On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Conditions of the favourable opinion
The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk.

Where a NHS organisation’s role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of approvals from host organisations.

Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publicly accessible database. This should be before the first participant is recruited but no later than 6 weeks after recruitment of the first participant.

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g. when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non-clinical trials this is not currently mandatory.

If a sponsor wishes to request a deferral for study registration within the required timeframe, they should contact hra.studyregistration@nhs.net. The expectation is that all clinical trials will be registered, however, in exceptional circumstances non registration may be permissible with prior agreement from NRES. Guidance on where to register is provided on the HRA website.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Ethical review of research sites

NHS sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).
Non-NHS sites

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

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Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document “After ethical review – guidance for researchers” gives detailed guidance on reporting requirements for studies with a favourable opinion, including:
- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The HRA website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website:
http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/

HRA Training

We are pleased to welcome researchers and R&D staff at our training days – see details at
http://www.hra.nhs.uk/hra-training/

| 15/EM/0007 | Please quote this number on all correspondence |

With the Committee’s best wishes for the success of this project.

Yours sincerely

[Signature]

Ken Willis
Chair

Email: nrescommittee.eastmidlands-leicester@nhs.net

Enclosures: “After ethical review – guidance for researchers”

Copy to: Mr David Clarke
Appendix E: Ethical considerations

**Informed consent:** Potential participants were given key information about the research, including the purpose, intended method, confidentiality issues and limits, by providing them with an information sheet. The information sheet was produced in English, Hindi and Urdu, to encompass the written forms of the spoken languages. Potential participants were given as much time as needed to decide if they wished to participate in the study prior to meeting the researcher. They were given the opportunity to ask any questions they may have had prior to written consent being sought.

**Confidentiality:** Participants were fully informed verbally and also on the information sheets and consent form about confidentiality and its limits, including information about storage and use of data. Whilst it was emphasised that identifying information will be removed from any write-up, participants were informed that other members of the triad may recognise their views, through a process of deduction. Participants’ right to withdraw during or after the interview was emphasised.

**Potential distress:** Participants were informed that they did not need to answer all the questions in the interview should they find them uncomfortable or distressing in any way. They were also reminded about their right to withdraw at any point during or after the interview. At the end of the interview, participants were given the opportunity to discuss the interview process and any distressing feelings that may have arisen from it and ask any questions they may have. All participants were given contact details for the researcher and her supervisor should they wish to discuss any aspects of the research further.
Appendix F: PIS and consent to contact English

INFORMATION SHEET

Title of study:
Psychological Therapy with South Asian Clients: Experiences, Roles, and Relationships within the Therapist, Client and Interpreter Triad

You are invited to take part in a research study that is taking place within an Improved Access to Psychological Therapies service (IAPT). Before you decide if you would like to participate we would like you to understand why the research is being done and what it involves. This information sheet explains the purpose of the research study and what will happen if you take part. Please do ask if there is anything that is not clear, or if you would like more information.

What is the purpose of the study?
There is not much research that has looked at the experiences of clients, therapists and interpreters working together in psychological therapy services. The research study aims to look at how South Asian clients, their therapists and interpreters talk about their experiences of psychological therapy when working together as a group or “triad”. It also aims to understand the roles that different members of the triad take and how these affect the therapeutic relationship within the group. We hope that if we have a better understanding of the experiences, roles and relationships of different individuals, it will help to inform and improve clinical practice when working therapeutically with clients who speak a foreign language.

Why have I been chosen?
You have been chosen because you meet one of the following criteria:
1. You are receiving or have received psychological therapy with an IAPT high intensity therapist using an interpreter.
2. You are an IAPT therapist delivering psychological therapy to South Asian clients with the aid of an interpreter.
3. You are working as a professional interpreter translating during psychological therapy within an IAPT service.

Do I have to take part?
No. It is up to you to decide whether or not to take part. Your decision will not affect the care that you receive or your current or future employment. Should you decline, please be assured that no further effort will be made to make you reconsider. Even if you do decide to take part you are still free to withdraw at any time and without giving a reason.

What do I have to do?
If you decide to take part you will be given this information sheet to keep and will be asked to sign a consent form. You will then be asked to take part in an interview.

V2.0, 26 January 2015
which will take up to one hour, but may take longer if required. All interviews will be conducted by the researcher Shabana Bashir and will be audio recorded. Word-for-word quotes from the interviews may be selected to be included in the final report; however, your name or any personal identifiable information will be removed from these quotes.

Confidentiality
All information that is collected about you during the interview will be kept strictly confidential. Your taped recorded interview will not have your name on it. No one except the researcher will be able to identify it. At the end of the study, a written report of the findings will be produced; however your name or any personal details will be changed in any written or verbal communication about the study, to make sure that your identity remains anonymous. The interview tapes will be destroyed after ten years and will only be accessed by the chief investigator (Shabana Bashir) and her supervisor (Dr Stephen Melzuf).

Will I receive any payment for taking part?
We will provide a small voucher of £20 for your time. We will also cover any expenses that you incur if you have to travel.

What are the benefits of taking part?
You have an opportunity to share your stories to help service users, mental health professionals and interpreters understand what it is like to work together in a psychological therapy where English is not a shared first language. The research will allow IAPT services to consider how care can best be provided when there is a triad of people working together in a psychological therapy, and how support could be provided in future to all members of the triad.

What are the risks of taking part?
We do not anticipate anybody coming to any harm by taking part in this research study. However talking about your experiences may be a difficult process. You do not need to answer any questions that you do not wish to answer. If you want to talk to someone after the interview, you will be given contact details for support services.

What if there is a problem?
If you wish to complain about or have any concerns about any aspect of the study please contact: [Contact information provided]. You could also contact the Patient Advice and Liaison Service on [Contact number] or email them at [Contact email].

What will happen to the results of the research study?
The results of this study will be written up as a doctoral thesis for the Clinical Psychology qualification. The findings may be published in a scientific journal. Some of your quotes may be used in the article. You will not be identifiable in the quotes. If you would like a copy of the results, please let the researcher know when you come for your interview so they can be given to you later.

V2.0, 26 January 2015
Who has reviewed the study?
The study has been reviewed by a service user group and academic panel at the University of Leicester. It has also been approved by the East Midlands - Leicester NHS Research Ethics Committee.

Contact for further information
If you are interested in taking part in this study, or would like some further information please contact the researcher Shabana Bashir. Her details are as follows:

Thank you for your time reading this information sheet and for considering taking part in this research.

V2.0, 26 January 2015
CONSENT TO CONTACT FORM

Tick this box if you might want to take part in the research and are happy to be contacted by the researcher: ☐

Your name:

____________________________________

Your address (including your postcode):

____________________________________

____________________________________

____________________________________

Your telephone number:

____________________________________

Your e-mail address (if you have one and like communicating via e-mailed):

____________________________________

V1.0, 05 December 2014
Appendix G: PIS and consent to contact Hindi

प्रतिभागी विवरण
आयोजक का प्रारंभ
दर्शक प्रतिभागी वाहनों के साथ मराठी विवरण: हिंदी, गुजराती और तमिल भाषाओं के साथ अंग्रेजी, हिंदी और तमिल
आप को मराठी विवरण क्षेत्र के लिए एक शीर्ष अपने में भाषा लेने के लिए आगमन मनोरंजन है। अगर आप लेना चाहते हैं तो आप को हम आप को सही सिद्धांत बताते हैं के ये विवरण प्राप्त हो सकता है और एस के वर्तमान स्थिति है: इस सूचना प्रतिभागी में आप को सही सिद्धांत जानने के लिए आयोजक का वर्तमान स्थिति है और समस्तात्मक आप अपने हिस्से रखते हैं। अगर आप को कोई सूचना प्राप्त है तथा जानकारी चाहते हैं तो आप पूछ सकते हैं।
इस अवसर का बना प्रयास है?
मराठी विवरण विवरण के में से एक सब साधन करते पड़ते विवरण क्षेत्र और तंत्रज्ञातों के अनुसार पर परिणाम यथा है। आप की सीमित स्थिति दर्शता है?
इस शीर्ष अपने सही सिद्धांत के में अपने हिस्से रखते हैं। उनके परिवार और मराठी विवरण के साथ मराठी विवरण के अनुसार के भाषा में है। वर्तमान स्थिति है। इस वर्तमान में हमारे साथी सामाजिक और उपरोक्त विवरण के साथ दर्शक प्रतिभागी के हिस्से की एक श्रेणी रहती है: जी जी जी जी जी जी जी जी। इस लघु श्रेणी के साथ समायोजित है।
मुझे कुछ बुद्धिमत्ता? आप को इस श्रेणी में भाग नहीं रखते हैं: के आप मानिस विज्ञानकीय अनुमोदन को पूरा करने हैं?
1. आप एक टीम का अनुमोदन दुराल एक उपचार विवरण क्षेत्र के लिए मानिस विज्ञानकीय विवरण क्षेत्र प्राप्त की जा रहा है। यह नहीं है?
2. आप एक विवरण के साथ एक मानिस विज्ञानकीय विवरण के दर्शक प्रतिभागी वाहनों के विवरण पुरालेख करते हैं?
3. आप एक विवरण क्षेत्र के में साधन मानिस विज्ञानकीय विवरण के दर्शक प्रतिभागी वाहनों के अनुसार के भाषा में भाषा नहीं रखते है?
मुझे कुछ बुद्धिमत्ता?
पत्ता आप अपने हिस्से के नहीं रखते है। यह नहीं?
आप का से विवरण आप के आयोजक का र्लीक्स और मानिस विज्ञानकीय कारक जो आप की विवरण नहीं रखते हैं। आप आप आयोजक का र्लीक्स और आप के आयोजक का र्लीक्स और मानिस विज्ञानकीय कारक जो आप की विवरण नहीं रखते हैं। आप आयोजक का र्लीक्स और मानिस विज्ञानकीय कारक जो आप की विवरण नहीं रखते हैं। पूर्वसूची करने के लिए नहीं बाहर जाता है। आप यह नहीं रखते हैं। यह नहीं रखते हैं। तो की आप अपनी मूल से किसी भी बाहर झुका है?

1
क्यों क्या कहा जा रहा?

अगर आप ऐसे दोस्तों के लिए तथा अगर आप को मदद करने के लिए इस जानकारी प्रदान करते, तो वहीं इसके लिए आपको यदि नहीं होगा, सोचना गर्मी के लिए दूसरी उपरोक्त लाभों में क्या लाभ होगा?

एक लाभ के वर्ग निकाली गई जपानी देश में क्या प्रतिरोध करना उत्तरण नहीं देंगे?

'बनाए रखिए' के लिए इसका उद्देश्य क्या है?

तत्परता के लिए इसका उद्देश्य क्या है?
लोग अधिकांकर मनोरंजन का विभार नहीं होगा?
इस अधिकार के आधार पर, मध्य या विभाजित मनोरंजन योजना के लिए इंटरनेट की कूटियों के रूप में किया जाएगा। संबंधीत कोई विशेष विश्वसनीय पसंदिध नहीं किया गया है। आपके खुले उद्देश्य से इंटरनेट वापस देने के लिए आरोप नहीं है। अपने आप में इसकी कूटियों का इंटरनेट पेशेवर तौर पर जमा नहीं होगा। और अपने आपके लिए इंटरनेट की कूटियों को आपकी स्वतंत्रता खोज नहीं होगी।

अधिकार की स्थिति को बदलना?
इस अधिकार की स्थिति को बदलना अवसर मिलता-प्राप्त है। इंटरनेट वापस देने के लिए इंटरनेट की कूटियों का इंटरनेट पेशेवर तौर पर जमा नहीं होगा। और अपने आप में इसकी कूटियों को आपकी स्वतंत्रता खोज नहीं होगी। अपने आप में इसकी कूटियों को आपकी स्वतंत्रता खोज नहीं होगी।

अभिक जानकारी के लिए संयुक्त?
अगर आप इस में भाग लेना चाहते हैं तो आपकी जानकारी प्राप्त करना चाहते हैं तो अपने आपके लिए इंटरनेट पेशेवर तौर पर जमा नहीं होगा। और अपने आप में इसकी कूटियों को आपकी स्वतंत्रता खोज नहीं होगी।

अभिक अभिनव का संयुक्त अवसर प्राप्त करना तो इस में भाग लेना चाहने के लिए और इस लोग में भाग लेने पर विश्वास के लिए अपका धन्यवाद।
आप का नाम: ____________________________________________

आप का पता: ( पीसीकोड के साथ)
__________________________________________________________
__________________________________________________________

आपका टेलिफोन नंबर:
__________________________________________________________

आप का ई-मेल अड़र्स (अगर आप ई-मेल के दुकान संपर्क करते हैं)
__________________________________________________________
Appendix H: PIS and consent to contact Urdu
Appendix I: Consent English

Title of research study: Psychological Therapy with South Asian Clients: Experiences, Roles, and Relationships within the Therapist, Client and Interpreter Triad.

Participant number:

CONSENT FORM

1. I confirm that I have read and understand the information sheet dated __________ for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason.

3. I am willing to take part in the interview for this research study and for the interview to be recorded.

4. I understand that my participation will be anonymous (that is, my name will not be linked with my data) and that all opinions I provide will remain confidential.

5. I understand that any of my data collected in this study will only be accessed by the researcher (Shabana Bashir) and her supervisor (Dr Stephen McElvish).

6. I agree to take part in the above research study.

______________________________
Name of Participant

______________________________
Date

______________________________
Signature

______________________________
Date

______________________________
Signature

V 2.0. 26 January 2015
प्रतिबंधी कंटेंट:

हिंदी में

शोध अध्ययन का शर्तावली: दक्षिण एशिया मांगों के साथ सार्वजनिक विषय, तथा और
द्रोणिक यथा के साथ आपकी, भूमिका और रिश्ता,
शोधकर्ता का नाम:

कृपया इनियुश करें:

1. मैं इस बात की मुद्दत करता हूँ कि प्रोटोकॉल अधिकार के लिए जो आपका पता

2. मैं समझता हूँ कि मैं यह आपसी न्याय और मैं जिस के कारण बताता जिसी भी

3. इस शोध अध्ययन की इंटरनल के लिए और इंटरनल भी हैं पता जसे जरूरी कराने के लिए स्वाभाविक हैं?

4. मैं समझता हूँ कि मैं भागीदारी गति रखा जा रहा (जो कि इसे भी भागी भी परिकार

5. मैं समझता हूँ इस अध्ययन में परिकार के किसी भी वेतन शोधकर्ता (क्षमा

हिस्सा जेनी वाले का नाम:  

शोधकर्ता  

हिस्सा जेनी वाले का नाम:  

दिनांक  

हस्ताक्षर  

हस्ताक्षर  

दिनांक  

हस्ताक्षर
Appendix K: Consent Urdu
Appendix L: Inclusion/Exclusion Criteria

Inclusion criteria: There is a different inclusion criteria for each of the three study participants; Clients, Therapists and Interpreters, which are listed below.

Clients were eligible if they:
1. Were aged 18 and above;
2. Had limited English proficiency;
3. Spoke Urdu, Hindi, Punjabi or Mirpuri, as these are the languages that the researcher is fluent in, thus allowing for the interview to be undertaken;
4. Were receiving or had received psychological therapy with an IAPT high intensity therapist using an interpreter;
5. Were able to provide informed consent.

Therapists were eligible if they were:
1. A high intensity therapist;
2. Working within an IAPT service;
3. Delivering psychological therapy to Pakistani clients with the aid of an interpreter;
4. Able to provide informed consent.

Interpreters are eligible if they were:
1. Working as a professional interpreter;
2. Translating during psychological therapy;
3. The most used interpreter, where more than one interpreter was used;
4. Able to provide informed consent.

Exclusion criteria: There was a common exclusion criteria for each of the three study participants; Clients, Therapists and Interpreters, which are listed below.

Participants were not eligible if:
1. They were unable to give informed consent;
2. All three members of the triad did not provide consent at the point of recruitment.
Appendix M: Interview guide

Introduction
Provide background, purpose, confidentiality, right to withdraw/not answer
Any initial questions from participant

Background
E.g., Age, gender, nationality, languages spoken, employment status, details of work.

Experiences

*Can you tell me about your experiences of the use of translation/interpretation within psychological therapy?*

*Can you tell me what you think might be the potential barriers to the use of translation/interpretation in psychological therapy?*

PROMPTS:
- *Can you tell me about an experience that has not gone well?*

*Can you tell me what you think might be the positive aspects of the use of translation/interpretation in psychological therapy?*

PROMPT:
- *Any positive experiences? What made this such a positive experience?*

*How do you feel linguistic differences influence cultural understanding of mental health and psychological therapy?*

PROMPTS:
- *In terms of your cultural background, what are your understanding/experiences of mental health and psychological therapy?*
- *Have you come across any cultural/religious issues related to psychological therapy and mental health and how have these impacted on you during therapy?*
- *Do you think that the current process of psychological therapy is beneficial to clients from diverse backgrounds?*
• Do people in the community know that you are here for therapy (Client)/work in this field (interpreter and therapist) and what do you think their views are?
• Would you recommend it to someone else?
  o Client: would you recommend psychological therapy to others?
  o Interpreter: would you recommend working as an interpreter in psychological therapy to others
  o Therapist: would you recommend working in psychological therapy with use of an interpreter or working with other language/culture diversity to other mental health professionals?

How do you feel therapy would be different if there were no cultural/linguistic barriers?
PROMPT:
  • Can u think of anything that hasn't been possible because of these barriers?

How have your views of psychological therapy changed based on your experiences of therapy?
PROMPTS:
  • What has changed? How has this impacted on you?

Roles

[The “triad” is the team or group comprising three people: the client, therapist and interpreter]

Can you tell me about your role within the triad?
PROMPT:
  • What does it involve?

How did this match up to your expectations of what your role would be?
PROMPT:
  • Have you had as much control as you would like?
  • Were you able to go into sufficient level of detail?
How do you think others within the triad see your role?

What do you think the roles are of others within the triad?

How does your role fit with the roles of other members of the triad?

PROMPTS:
- Have there been any problems or issues?
- Have you had a differing view from others in the triad and how was this negotiated?

Outside the context of psychological therapy, what kind of support did you have?
- Client: Did/do you have faith in the therapy process and was it helpful? Support from others?
- Interpreters and therapists: did you have adequate training and knowledge prior to starting? Support from others?

Relationships

Explore relationships within the triad using stones. Respondent is given three stones and asked to position stones based on questions asked. Explore positioning of stones.

Position the stones based on who you feel had the closest understanding of you during therapy

PROMPTS: Explore positioning of stones and reasons behind this?
- What helped them to understand you better?
- What did not help?

Position the stones based on who you feel most actively contributed to the therapy process

PROMPTS: Explore positioning of stones and reasons behind this?
- What contribution did they make?
- How was this different to the contribution of others?
Position the stones based on who you found most helpful during therapy.
PROMPT: Explore positioning of stones and reasons behind this?
  • What made this relationship helpful?
  • How was it different to other relationships within the triad?

Position the stones based on who you feel you had the closest relationship with during therapy.
PROMPT: Explore positioning of stones and reasons behind this?
  • What made the relationship close?
  • What are the positive aspects of your relationship?
  • What did you do? What did they do?

Ending

Overall what have u learnt from this experience of psychological therapy that u will take forward with you?

Do you have any recommendations/advice for others?
PROMPT:
  • How could it be improved?

Is there anything else you would like to add?

Review consent, provide opportunity for the interviewee to discuss any queries and be given contact details: thanks, any questions/queries, contact details given should they need to contact me/supervisor, what happens next (feedback, data analysis, dissemination of findings).
Appendix N: Certificate from translation company

Tuesday, 26 July 2015

Dear Mrs Bashir,

Thank you for using Lotus Bonnell translation services. We pride ourselves on our ability to deliver our services on schedule for all our clients. I sincerely hope that our translation services have been provided to your satisfaction.

Having examined the supplied transcripts in Urdu and Miranji, I can confirm that the original translation into English is sound and highly accurate according to the accepted industry standards. The words and phrases are well-matched and we found that all the statements have been transmitted properly into English by the original translator.

I wish you all the best and hope that you will consider our company for any future services that you require.

Yours sincerely,

Mr Aaqib Raza
Chief Information Officer and Manager of Copywriting Team
Appendix O: Research Quality and Integrity

1. Sensitivity to context:
Developing an awareness of the existing context in which the research is being undertaken is integral to quality appraisal. The researcher actively worked to develop an awareness of relevant existing literature pertaining to participant’s experiences of psychological therapy. Furthermore a systematic literature review was undertaken by the researcher, looking at the existing literature on therapist’s experiences of working with language interpreters in psychotherapy.

Given the recognition of social and cultural factors in influencing narrative accounts, awareness of the wider context in which this research was undertaken was seen to be integral to the research process and quality appraisal. The researcher also had some awareness of the wider socio-political context in which the study was being undertaken including the current discourses around refugees, asylum seekers and an increase in demand for psychological therapy. The researcher is also aware of the taboo in accessing therapy services held by Pakistani communities.

Awareness of the role of the researcher in the co-construction of narratives was also key. The researcher kept a reflective diary and used supervision to reflect on her own beliefs and assumptions in an attempt to remain grounded in the participant’s accounts throughout the interviews. Reflexivity involves researchers understanding and acknowledging the role that they play during the creation and interpretation of data (Harding, 1992). Reflexivity plays a central role in qualitative research and can take many different forms. Key to reflexivity is the ability to understand and acknowledge one’s standpoint and epistemological positioning (Yardley, 2000).

The influence of power balances in research is also an important contextual factor to be aware of. The researcher emphasised that the project is being undertaken as part of a doctorate, therefore creating a distance from the NHS organisation in which therapists would work.
2. **Commitment and rigour**
All the interviews were transcribed verbatim by the researcher herself over an extended period of time. The Pakistani language interviews were also subsequently translated into English by the researcher. This allowed the researcher to immerse into the data and reflected the researcher’s commitment to the analysis process. The researcher also used supervision to discuss different aspects of the research process and method of analysis to ensure subsequent stories or accounts were grounded in the client narratives.

3. **Transparency and coherence.**
Transparency and coherence were maintained by the researcher providing detailed descriptions of the data collection and analysis process in the current research. Verbatim quotes were presented in the research to ensure narratives presented were grounded in the participant accounts. The researcher also kept a reflective diary and used supervision to reflect on and discuss personal experiences, motivations, challenges and pressures.

4. **Impact and importance.**
Through review of the existing research it was evident the triadic experiences of Pakistani Clients, their therapists and interpreters when working together in psychological therapy were limited. The findings of the study will be of importance to numerous stakeholders, including the study participants, psychological and interpreting services and The University of Leicester. The researcher plans to disseminate the study findings to the key stakeholders, present the study at relevant conferences and also publish the study in a peer-reviewed journal to maximise its impact.

**References**


Appendix P: Quotes in Urdu Script

Urdu Language Quotes

Triad One

Power Narrative: Haider’s quotes

My opinion is it’s not a matter of good or bad, it is a matter of need. Because we find speaking English difficult, and then I got ill, then I went for treatment, so obviously when you go to the doctor sometimes they can give you medicine but sometimes there is a situation where you need therapy and then we have to do all this. So it is a need, I never thought of it in terms of good or bad. (Haider)
You are helpless (in language), you are ill, you have gone to get treatment... so as much as someone can be understanding towards you, the better. But if someone doesn't understand you there is not much you can do... (Haidar)

آپ صحیر ہیں، آپ بیمار ہیں علاج کے لئے گیا ہیں... تو جنتنا چیز آری آپ کو سمجھنے اتتیا نہیں ہے، لیکن انور
سمجھیں تو آپ تو اتنا تو نہیں کر سکیں...
I never thought that from a mental perspective it is possible to be so restless. So you can’t do anything despite your body being totally healthy. So I have learned that this is possible and there is no- as I mentioned earlier that people give different excuses for this, which aren’t right, so I learnt that these reasons are actually signs of a real illness, in the same way as the body can get ill...

(Haider)
Culture Narrative: Haider's quotes

Actually, I will tell you honestly. In our religion, maybe there is something written. But the way we follow our religion, if you go to a traditional local cleric, and ask him what is the religious standpoint or what does Islam say about this (mental health), he will just say that you go and read these verses, go home and sit down and read these other verses for protection, or he will say that this is a very serious matter and you have been possessed by a spirit, and will beat you maybe (in an exorcism), or send you to someone who might burn you or something like that. So these are not actually religious - this is not our religion at all. This is just cultural, superstition that is all. (Haider)
... as I mentioned that sometimes you would get a good interpreter who is from the same country as you. Come over from the same country, so there is a bit of you feel that if someone of your own background understands you, and then that person is telling the doctor exactly the right thing, then you get reassured.

(Haider)
Triad Two

Power Narrative: Ibrahim’s quotes

The way in which he was trying to help me by explaining to the therapist, I really felt he was helping me from his heart and I also felt it with the therapist, so they’re more or less close. The reason why I felt it with the therapist was because they were helping me and I felt they understood me well... I’m very grateful to both of them. (Ibrahim)
I think it’s good for every person. I’m just shocked that a lot of people haven’t even heard of therapy and that many people don’t get its benefits. (Ibrahim)
Culture Narrative: Ibrahim’s quotes

In my culture they say... I’ve spoken to a lot of people and they say what, you’ll be okay just don’t stress. You’re stressing a lot a lot of people have told me that and then a lot of people have said go to see the spiritual healer (peer) and this and that but we don’t believe in spiritual healers that’s why I didn’t go. But I...people say you’re putting this pressure on yourself and try, but they don’t understand that these pressures happen by themselves, even if a person doesn’t try they appear. (Ibrahim)
To make myself better I talk to a lot of people and they give me different answers about what the causes could be. Some think you’re born with it and I used to think that you’re born with it but I now after therapy I think what if I put too much pressure on my mind and it happened cause of that. (Ibrahim)
## Appendix Q: Chronology of research

<table>
<thead>
<tr>
<th>Research Step</th>
<th>Date</th>
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<tbody>
<tr>
<td>Research proposal prepared</td>
<td>May 2014</td>
</tr>
<tr>
<td>Review of research proposal by service user reference group</td>
<td>September 2014</td>
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<tr>
<td>University Peer review of research proposal</td>
<td>October 2014</td>
</tr>
<tr>
<td>Submission to NHS Ethics committee</td>
<td>December 2015</td>
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<tr>
<td>Ethics Approval Granted</td>
<td>February 2015</td>
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<tr>
<td>Research and Development Approval granted (Site One)</td>
<td>May 2015</td>
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<tr>
<td>Write-up of chapter one</td>
<td>August 2015</td>
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<tr>
<td>Research and Development Approval (Site Two)</td>
<td>October 2015</td>
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<tr>
<td>Research and Development Approval (Site Three)</td>
<td>January 2016</td>
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<tr>
<td>Recruitment of participants</td>
<td>May 2015 - February 2016</td>
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<tr>
<td>Interviews conducted</td>
<td>November 2015 - February 2016</td>
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<tr>
<td>Transcribing, Analysis and Write up of chapter two and three</td>
<td>December 2015 - April 2016</td>
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<tr>
<td>Submission of thesis to University of Leicester</td>
<td>April 2016</td>
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<td>Research Viva</td>
<td>June 2016</td>
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