

The third person in the room:
The impact of the interpreter on the counselling process
with non-English speaking clients.

Thesis submitted for the degree of Doctor of Philosophy

Merih Bektas Fidan

Institute for Lifelong Learning

University of Leicester

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Abstract

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This study explores the dynamics of the triadic therapeutic relationship between interpreters, counsellors and non-English speaking clients in a triangular research design. It comprises three parts:

In part one, two focus groups were held with a group of interpreters and of counsellors to explore common issues and general concerns that were pertinent to the relevant fields. In part two, twenty-nine semi-structured individual interviews were carried out with another group of interpreters and counsellors with the aim of exploring the issues that arose in the focus groups. In part three, a group of clients were interviewed to explore their experiences of receiving emotional help through interpreters.

Participants were recruited through interpreting agencies and counselling organisations. The data was analysed, using Thematic Analysis. The overarching themes show that all the participants wanted to trust each other and expected to be trusted by the others. Confidentiality came out as a common concern across the data sets. Translation and language issues, cultural matters and organisational restraints were found to be barriers to establishing a working alliance. All participants expected practitioners, including language interpreters, to have relevant knowledge, awareness of their own strength and weaknesses, to be critical and flexible, and to demonstrate certain personal qualities.

Overall, the participants were apprehensive about the triadic therapeutic process which they found to be emotional and full of surprises. They also found the process helpful and rewarding. The findings of this triangulated research suggest that mental health interventions and relevant educational programmes for counsellors and interpreters should address the complex needs of a multicultural client group and include an understanding of three-dimensional relationships.

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List of Abbreviations

APA	American Psychological Association
BACP	British Association for Counselling and Psychotherapy
BME	Black Minority Ethnic
BPS	British Psychological Society
CPD	Continuing Professional Development
GT	Grounded Theory
IAPT	Improving Access to Psychological Therapies
IPA	Interpretative Phenomenological Analysis
ITI	Institute of Translation and Interpreting
MHP	Mental Health Professional
NAJIT	National Association of Judiciary Interpreters & Translators
NCCC	National Center for Cultural Competence
NCIHC	National Council on Interpreting in Health Care
NHS	National Health Services
NICE	National Institute for Health and Clinical Excellence
NIMHE	National Institute for Mental Health in England
TA	Thematic Analysis
UNHCR	United Nations High Commissioner for Refugees
WHO	World Health Organization
WGMISAC	Working group of the Minnesota Interpreter Standards Advisory Committee

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CHAPTER 1: INTRODUCTION

Overview

This chapter seeks to ground the research in terms of the background of the study and the rationale for carrying it out. It includes the researcher's journey that led her to explore the dynamics and the processes that have been observed in health, mental health and the interpreting fields for a long time. The chapter ends with a section explaining the structure of the thesis.

The motivation for this research

The research rationale: why interpreters and interpreting?

Until a change in personal circumstances led to my move to the UK, I was working as a clinical psychologist in Turkey where psychology, as in many countries, is thought of mostly in Western terms and without critical cultural perspectives. I thought that exploring the origins of the theories and systems that were taught to us within its original context would allow me to develop more intellectually- and culturally-informed insights and an understanding of mental health and the associated areas.

While I was trying to enter the clinical psychology field in the UK, I was gradually drawn towards a new area, in which I had never thought of practising: Interpreting and Translation. Although I had had experience of translating articles within the psychiatry department where I was working in Turkey, I did not know that interpreting existed in my country, or indeed throughout the world, on the scale that it does. Nor did I, at first, see its relationship to my professional background. However, observing my fellow countrymen and women in a different environment, the Midlands, without any knowledge of the culture and the language, and with considerable hardship, made me think deeply in terms of what I could do about it. As time passed, while I was working as an interpreter in hospitals, surgeries and mental health units, I realized that my colleagues who were also working in the mental health field were frustrated by the challenges imposed by new arrivals from various ethnic backgrounds, and that they were vulnerable to being isolated and were trying to succeed without sufficient institutional support. Witnessing the health care practitioners' frustration concerned me more when I observed several clients

expecting a miraculous ‘psychological prescription’ (Burchell, 2009) for their emotional disturbances. I witnessed some professionals being trapped between their own cultural assumptions and working styles, and the clients’ cultural understanding and attitudes towards the system and the staff.

I soon realized that I was in possession of something useful that could turn into something helpful: I could speak both Turkish and English, I have had some expertise in my own culture and I have learned much about the new culture. I could offer professionals cultural explanations, when necessary, to facilitate their understanding of the culturally-different clients and to prevent misinterpretations of client behaviours. I could also help clients to understand my colleagues and their way of working within the system to enable them to better utilize the services they were offered.

I have now been working in the interpreting field since 2001. I have had the opportunity of working from inside and, also, from outside both the mental health and the interpreting fields. Whilst working with various mental health professionals, I realized, though, that I did lack professional listening skills that would allow me to accommodate different perspectives in my work. I also gradually realized how much we, as psychologists, tended to focus on the assessment and the changes that we expected clients to achieve. Although my psychology training had given me invaluable knowledge and equipped me with numerous skills, I felt that the new opportunities that I was encountering would require different skills and approaches, and so I undertook a series of counselling courses.

It is this continuous pursuit of learning and wanting to make improved contributions that has led me to work at a doctoral level, with the hope of giving voice to clients, interpreters and mental health professionals within my chosen contexts of study.

Why counsellors and counselling?

In Turkey, counselling is in general regarded as the provision of guiding or coaching skills. In Britain, it operates differently in terms of leading to change in individuals in accordance with their own choices. Influenced by democratic ideals such as liberty, freedom, equality and the ‘Humanistic Movement’ in the USA in the 20th century (McLeod, 2000), counselling offers people time to choose to change at their own pace through talking therapies. The person, especially in a Person-Centred Approach (Rogers, 1961), is thought to go through an ever-changing process of ‘becoming a person’,

fulfilling his or her needs for self-actualization, to be loved and valued by others (McLeod, 2000). In this approach, the core conditions between client and therapist are empathy, congruence, unconditional positive regard, and it is the client, not the counsellor that is the agent for change (Rogers, 1961).

This seems to be verified when working with British native individuals. However, it can be daunting for people who do not have the same understanding of choice and have never been given the full responsibility for their own lives. As McLeod (2000, p.30) asserted:

‘Counselling is an activity that is inextricably bound up with the culture of Western industrial societies, and is therefore not necessarily relevant to the problems experienced by members of other cultural groups’.

Counselling and interpreting have something in common: that is that practitioners should put aside their assumptions and hold a simultaneously close and yet distant relationship with clients; close enough to establish an alliance for the sake of the therapeutic relationship and distant enough in order not to break the code of conduct. Even though the client is known, mental health practitioners should not develop a relationship with that person even after the sessions. In practice, though, this is hard to achieve with refugee clients, due to their limited access to information and services. Clients might have high expectations from therapists in terms of quick solutions, and interpreters might have to explain to clients how health and social care systems work.

Interpreters act as if they are the gate keepers of the system. They are usually asked to fulfil different roles, such as a culture-broker, a translator and an expert in providing the cultural context for both clients and therapists. The dynamics attached to these additional roles can present further challenges for interpreters, especially when they are not adequately trained. The fact that the interpreters are expected to cover various aspects of the clients’ needs is one aspect which may prove difficult. Health professionals may also encounter difficulties when working with demanding clientele. Cultural competence is therefore a crucial skill in these situations, and therapists should explore patients’ ways of thinking and underlying concepts (Bjorn, 2005).

Counselling in the West does not necessarily mirror that of other parts of the world, especially the East. This calls for both counsellors and service providers to develop new

insights in order to familiarize themselves with each other. But who is supposed to educate counsellors about culturally different clients? Who will educate clients about the working style of the therapist? What about language? Foreign clients need a very long time to understand the system in their new home. As far as I could observe, practitioners seemed to lack sufficient time, and are sometimes unwilling, to educate themselves further about clients from Black Ethnic Minority (BME) backgrounds including asylum seekers. It also seemed that the interpreter was left to take up the challenge. These observations led to further research involving whether the interpreter is prepared to do so, or whether a therapist could be a 'mini-ethnographer' (Bhui & Morgan, 2007) of his or her client?

Interpreters could have considerable impact on the members of the triad as well as the process: they can change the whole dynamics and be damaging if not trained adequately when working with complex cases. This inadequate training can prevent them providing a professional service. None of the elements of the triadic framework (in alphabetical order: client, counsellor and interpreter) is less important than the other, or can be ignored. In fact, all members of the triad need a sensitive and an inclusive approach to establish a functional alliance that leads to therapeutic efficacy (Raval, 1996). Even basic counselling skills such as active listening, empathy and congruence are argued to work differently when working with culturally different clients (Matthews and Peterman, 1998).

Despite the substantial difficulties of the third person's joining a therapeutic encounter, Dubus (2009) sees a positive aspect to this issue. She argues that therapeutic encounters with interpreters (called 'Paraprofessionals') would give therapists more time to think, reflect and observe. This 'Team Approach' model encourages sharing responsibility of improving client's emotional health by using mental health professionals' and interpreters' expertise. This arrangement gives the therapist a meta-position to easily overview the process and observe both sides' feelings and gestures (Dubus, 2009).

Working with an interpreter can make the therapeutic process longer than it would be in a dyadic one. Long pauses and comments made by the therapist and the client can tire the interpreter (Bjorn, 2005). This may mean that the therapist should work through much less information in order to produce positive psychotherapeutic outcomes without undermining the important connection between the client and the therapist.

Rationale for the study

The rationale for the research was to provide academia and the interpreting sector with further insights and knowledge. Difficulties faced by the interpreters, the counsellors and the clients needed further exploration to be communicated to the relevant authorities.

The literature thus far available is limited in addressing the use of interpreters working with ethnically different clients (Dubus, 2009; Miller, Martell, Pazdirek, Caruth & Lopez, 2005). There is much related literature on the use of interpreters, particularly in the medical field; but few studies explored the interpreters' experience of the interpreting process (Fatahi, Mattson & Skott, 2005; Hudelson, 2005; Ozzie, 1982). Interpreting in psychotherapy is naturally different from legal interpreting, for example, as it involves an ongoing relationship with the client, and requires working with highly emotional content for extended periods (Miller et al., 2005). Working with interpreters can be understood as a positive development in helping these clientele, as well as a challenge. It is likely to bring new insights and practices for mental health professionals, especially when therapists are open to new cultural and instinctual insights (Trivasse, 2009).

The ultimate aim is to promote the development of more effective, sensitive and inclusive therapeutic approaches. One of the outcomes might be recommending tailored support and training in the counselling and interpreting fields, in line with the perspective of Mewborn, who argues that cross-cultural researchers should conduct research that is beneficial not only to them, but also to the population being researched (Mewborn, 2005), which is also one of the Stile's (1993) criteria for the quality of a qualitative research.

Structure of the thesis

The main body of the thesis comprises seven Chapters:

1) Introduction, 2) Literature Review, 3) Methodology, 4) Results: Interpreters, 5) Results: Counsellors, 6) Results: Clients, and 7) Discussion.

Chapter 1 begins with the researcher's motivation for the study. It then describes the background of the study; aims and design of the study; rationale for the study; and finally, the structure of the thesis.

Chapter 2 provides an extensive literature review. It starts with the definitions of psychotherapy and counselling, and their development in modern times. Then it proceeds to explore the nature of triadic therapeutic relationships and cross-cultural psychotherapeutic approaches and practices. It details mental health, communication, language and power related issues, and their impact on mental health. Chapter 2 also discusses cultural competence in relation to working in a triadic framework where interpreters can utilize various roles, and therapists require further skills.

Chapter 2 finally explores interpreting related topics starting from its theoretical background to the professional and practical matters.

Chapter 3 discusses the methodology used in carrying out this research project. First, an overview of the chapter, then a rationale for the chosen research methodology are presented. In this part, the philosophical assumptions of the researcher, the researcher's reflexivity and reflexive observations, research design, the data collection and the analysis methods are discussed. Also, how the participants were recruited and selected, and how the analysis was carried out at each stage, and how the quality check in the study was ensured are explained.

Chapter 4, 5 and 6 report the findings and the outcomes of the analyses for all data sets. Chapter 4 presents the results of the analyses of the Interpreters' data; Chapter 5 describes the outcomes for the Counsellors' data and Chapter 6 presents the outcomes of the analyses for the Clients' data. The findings chapters begin with a table displaying all the themes and categories that were emerged throughout the analyses. The findings are reported in the order of the recruitment of the participant groups, and relevant extracts from the participants are quoted. Each chapter outlining the findings is followed by a summary of the themes and categories which emerged in that theme.

Chapter 7 covers the discussion section. It begins with an introduction to the research topic and over-arching themes that were developed to discuss the overall results in the light of the existing literature. The arguments are illustrated in a suggested model that has been developed in this study.

Chapter 7 proceeds with the researcher's contribution to the literature, the existing knowledge and the method. The chapter continues with the limitations of the study, an outline of the recommendations of the researcher, and the implications of the study in the

relevant fields with some suggestions for its dissemination. This chapter ends with a conclusion section in which all findings are summarized, using the participants' phrases and the researcher's metaphor.

The next chapter includes the literature review by which it is aimed to develop a comprehensive understanding of the background of, and the relation to which the researcher's own research will be developed.

CHAPTER 2: LITERATURE REVIEW

Overview

The literature review seeks to provide information on the definition of counselling and therapy, what they entail and how they operate and their historical background. The relationship between culture and therapeutic approaches and practices, the impact of culture on therapeutic work with culturally different clients, the nature of the triadic therapeutic relationship between clients, interpreters and counsellors, and language issues with an emphasis on immigration and mental health, the background of immigration issues in Britain in relation to language and mental health issues will be detailed.

The theoretical background of human communication, interpreting and current practices both in the UK and the world will also be examined. Finally, the professional issues pertinent to interpreters and working with interpreters in terms of good practice will be noted.

What is psychotherapy and counselling?

This section looks at the definitions of and variations between counselling and psychotherapy with a short historical background.

Psychotherapy works towards alleviating psychological distress of the person through talking rather than drugs; therefore, it is often referred to as 'talking therapy' (BPS: British Psychological Society).¹ It is an intentional and a collaborative relationship (American Psychological Association)² between a client and a professional with whom people examine their feelings and thoughts, and learn how to adjust or change. Holmes and Lindley (1989) note that the therapeutic relationship is a systematic process that produces change in peoples' cognitions, feelings and behaviour to increase individuals' sense of well-being. Talking cures are not new and human beings have eased troubled minds through verbal communication. In that sense, psychotherapy has always existed in one form or another (D'Ardenne & Mahtani, 1999).

¹<http://www.bps.org.uk/psychology-public/find-psychologist/psychotherapy-register/find-chartered-psychologist-specialising->

² <http://www.apa.org/helpcenter/understanding-psychotherapy.aspx>

Counselling is similarly a form of talking therapy that explores the person's personal development and creating adjustments to his or her life. It may involve talking about life events, feelings, emotions, relationships, ways of thinking and patterns of behaviour. Therefore, its main aim is to give the 'client' an opportunity to explore, discover and to clarify ways of living more satisfyingly and resourcefully (Burchell, 2009). The therapist will listen, encourage and empathise, but will also challenge to help the client to see their issues more clearly or in a different way. For that reason, counselling is not about giving advice nor is it a chat with a friend. The therapist helps the client to understand themselves better and find their own solutions to resolve or cope with their situation.³

Dryden and Feltham (1993) describe counselling as a principled relationship characterized by the application of one or more psychological theories and a recognized set of communication skills, modified by experience, intuition and other interpersonal factors, to clients' intimate concerns, problems or aspirations.

Counselling has historical roots in practical guidance and problem-solving issues. Feltham and Horton (2000; p.2) describes both counselling and psychotherapy as below:

'Counselling and psychotherapy are mainly, though not exclusively, listening and talking based methods of addressing psychological and psychosomatic problems and change, including deep and prolonged human suffering, situational dilemmas, crises and developmental needs, and aspirations towards the realization of human potential...'

There has been a debate over the difference between psychotherapy and counselling, although their result is similar (McLeod, 1998). To Mulhauser (2010) the difference is largely academic; both are similar courses of therapeutic communication treatment. McLeod (1998) argues that one of the main differences between the two is that counselling has been widely involved with the educational and voluntary sectors. It has always had a life outside the medical field. But psychotherapy is closely related to the medical arena, particularly with psychiatry, clinical psychology or psychiatric social work. He adds that counselling can be regarded as an extension of psychotherapy or as a way of marketing psychotherapy to the new consumers (ibid, 1998).

³ <http://www.bacp.co.uk/crs/Training/whatiscounselling.php>

Another difference is argued to be the time required to see any benefits. Counselling usually refers to a brief treatment that centres on behaviour patterns. It is also known as 'brief psychotherapy' (McLeod, 1998). Psychotherapy on the other hand focuses on working with clients for a longer term and draws from the insight into emotional problems. It must be noted that counselling is not only a relationship between two individuals or a personal learning but also a social activity with social meaning. Therefore, counselling as a social institution is embedded in the culture of modern societies (ibid, 1998).

Who are the mental health professionals?

Mental health professionals (MHP) are specifically trained people whose aims are to improve the mental health of individuals, couples, families and so forth. Depending on their training, some MHPs focus on enhancing the quality of people's relationships, and some focus on treating their mental health illnesses. Their titles range from psychiatrists to counsellors. There are mental health nurses, psychologists, psychotherapists and so forth. In this hierarchy, psychiatrists are the medically trained professionals who work from a biomedical approach and have the authorisation of prescribing medicine to the patient with a mental disorder.⁴

Psychologists hold a PhD in psychology, have training in psychological testing and can perform research protocols. Some psychologists who are trained specifically to do clinical work (rather than research) have "PsyD" (Psychology Doctorate) as their academic degree, rather than PhD (Sherman, 2011).

Psychotherapist -- This is an umbrella term for any professional who is trained to treat people for their emotional problems. Depending upon their academic degree, a psychotherapist can be a psychiatrist, psychologist, or social worker (among others), and work with individuals, couples, groups, or families (Sherman, 2011). They tend to have more extensive and sometimes longer training before becoming a psychotherapist than counsellors.

⁴ https://en.wikipedia.org/wiki/Mental_health_professional

A counsellor is an experienced trained person who aims to listen with empathy to help the person deal with any negative thoughts and feelings without being judgemental.⁵

A counsellor will utilise psychotherapy to help clients going through mental health difficulties. In some cases, professionals may choose to call themselves a psychotherapist. Others may refer to themselves as a counsellor.⁶ So, they are used interchangeably. Whether it is advisable to see a counsellor or a psychotherapist is a common question asked. It is mainly caused by a grey area in the UK due to the overlap in their training and practice whereas in some countries the differences are clear-cut.⁷ BACP notes that counselling and psychotherapy are not regulated by law, but practitioners in these fields are still subject to long term training and supervision, and they require life experience.⁸

Both aim to reduce stress and anxiety in clients, improving their self-esteem, encouraging them develop further skills to cope better. Some see them helping people with what might be considered "normal" or "moderate" psychological problems, such as feelings of sadness resulting from major life changes or events (Compass & Gotlib, 2002).

A brief history of psychotherapy and counselling

Hypnotism was developed by Franz Anton Mesmer (1734-1815) in the eighteenth century as a cure for psychosomatic problems and mind related disorders. It was the first scientific way to access to the minds of patients. French psychiatrists Charcot and Janet in 1880s, used this method to work with 'hysterical' patients (in McLeod, 1998). The medical professionals, mostly psychiatrists, using this technique soon realized that without the rapport of the patients they would not be able to work with them in terms of mutual relationship as a talking treatment. McLeod (1998) notes that the notion of the 'unconscious' mind that was used by hypnotists was the main tool in hypnotism.

Sigmund Freud facilitated the transition of hypnotism to Free Association and to psychotherapy later (Feltham & Horton, 2000). His major contribution is argued to put his ideas into a theoretical treatment model called Psychoanalysis (McLeod, 1998). Freud briefly asserted that adults' emotional problems stem from childhood experiences; the

⁵ <http://www.nhs.uk/conditions/counselling/pages/introduction.aspx>

⁶ <http://www.counselling-directory.org.uk/psychiatrists-psychologists-psychotherapists-counsellors.html>

⁷ <http://www.harleytherapy.co.uk/counselling/difference-between-psychotherapy-and-counselling.htm>

⁸ <https://www.bacp.co.uk/student/become.php>

unconscious thoughts and feelings mirror themselves through dreams; unwanted thoughts and feelings are suppressed by defence mechanisms; and the human mind consists of Id, Ego and Superego that are different levels of selves (Ashdown & Homa, 2010). After Psychoanalysis was taken to America, psychotherapy and counselling have become more widely available to the masses particularly due to new consumerism, secularization and modernization (McLeod, 1998).

Counselling too has emerged, evolved and changed rapidly in the second half of the twentieth century. It contains different themes, emphases, practices and schools of thoughts. It has been getting more diverse in its applications, which reflects economic, social and cultural forces. McLeod (1998, p.29) summarized the history of counselling in the following order:

- Pre-industrial times: people with emotional problems were helped by priests or other members of community;
- In the early years of the nineteenth century: there had been rapid development of institutions and professions that aim to help people with ‘mental illness’ due to secularization of the society;
- In the middle years: hypnosis was developed as a way of helping people with psychological problems;
- Late nineteenth century: Freud developed psychoanalysis, integrating psychological, medical and philosophical thoughts; then Carl Rogers developed Client-centred theory as a mean of helping people, which was more acceptable and popular.

Counselling can now be offered in medical, educational, community and even in business settings; and counsellors can work with people who have chronic conditions like diabetes, AIDS; people with addiction problems; children with developmental disabilities, people with debt problems, educational concerns, and with people who seek asylum who were persecuted and traumatized. McLeod (1998, p. 24) also listed the factors that facilitated the rapid expansion of counselling particularly below:

- that caring professions such as nursing were too busy to care for emotional problems of patients,
- that counselling generally receives positive media attention and coverage; that a sector has been set up in which counsellors sell their expertise,
- that organizations are encouraged to use the services for their employers to make them feel cared for and more effective in their work.

One of the main reasons for the rapid expansion of therapy particularly in the USA is being a new state in which people are subject to massive social change and transformation (Cushman, 1995). This trend was accompanied by Capitalism through which individuals had to promote, present and even sell themselves as new identities. As McLeod (1998) suggests, these rapid developments and changes have resulted in an erosion of the structure of families and communities, which have produced ‘empty selves’ (p.22).

Sociologists argue that we are in a new era called post-modernism (Elliot, 1999) or late modernity (Giddens, 1993) in which the ideas of Enlightenment (or the ideas of ‘Reason’) are lost. People in the modern world are encouraged to become highly reflexive in terms of their choices and expectations. Yet, psychotherapy was ready to offer new identities and selves to the masses (McLeod, 1998, 2001).

Counselling plays an important role in promoting an image of a person as an intrinsically autonomous and separate being. The person on his or her own is considered at the centre of both the problems and the solutions in the West. However, as McLeod (1998) notes, it seems to be that this understanding of an individual and his or her emotional problems in the West will be limited and be challenged by other forms of helping practices in cultures other than the Western culture.

Mental health, culture and mainstream services

This section begins with a clarification of the positions of the research sample in relation to various cultural groups in the United Kingdom. It then proceeds with the definitions of mental health, culture and its cultural variations. The indigenous meanings, the western type of mainstream services, and a summary of the research on psychotherapy will be detailed. Finally, a cultural psychological understanding from other cultures than the British culture will be examined.

In Britain, ethnic minority communities are often described under an umbrella term BME. BME stands for Black Minority Ethnic, and includes people from Black African, African–Caribbean, South Asian, the Middle East and Chinese heritage. It also includes other white and non-white minority groups whose cultural heritage differ from that of the majority population (National Institute for Mental Health in England, NIMHE, 2004).

Britain has a long history of accommodating people from different cultures for economic and political reason. Although the legal status and personal and cultural backgrounds of these individuals differ significantly, they are classified as ethnic minorities. They might come from Europe, the USA or Africa to work, to study and/or to seek shelter from religious or political persecution. Some are economic or social immigrants and others are refugees and asylum seekers. Some can speak the English language when they arrive in Britain, but do not still feel confident in using it in their formal with authorities.

The participant groups of this research can be described as Black and Ethnic Minority (BME); the clients were from Turkey and Bosnia; interpreters were from Europe, India and the Middle East, and counsellors were from Europe, Africa, Caribbean and the Middle East. A few of the clients were asylum seekers, and the majority of the participants in the counsellors' and interpreters' groups were refugees who came to Britain to work and/or to seek safety in the past. There is no doubt that getting used to the host country and understanding the embedded systems had been tough for all participants of the research, but the clients particularly felt the adverse impact of limited language skills more than the others, which contributed to their mental distress.

Culture and mental health

Culture can be defined as a set of guidelines that are inherited by members of a society. Those guidelines inform individuals how to view the world, how to experience it, and how to behave in relation to other people (Helman, 2000). The impact of culture on mental health is inevitable as it affects ways of being, behaviours, interpersonal relationships, and understanding of the environment in which people live (Lago,1996; p.34).

The World Health Organization⁹ (WHO) defines mental health as

‘...a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully and is able to make contribution to his or her community.’

⁹ http://www.who.int/features/factfiles/mental_health/en/

Mental health is affected by culture and community. People from different cultures vary in what they see as being a problem and how to seek the help they need (D'Ardenne & Mahtani,1999). Fraser and Blishen (2007) from the Mental Health Foundation define young person with a good mental health as:

‘one who can develop emotionally, creatively, intellectually and spiritually; initiate, develop and sustain mutually satisfying personal relationships; face problems, resolve them and learn from them; be confident; be aware of others and empathize with them; laugh, both at themselves and at the world’.

Bhui and Morgan (2007) argue that mental stress can be an outcome of family or interpersonal dysfunction, of adverse life events and misfortune, or as a consequence of a breach in religious and cultural codes of conduct, which can be seen in some cultures. Thus, approaches to mental stress and illnesses vary and are embedded within the culture. For example, Motschnig and Nykl (2011) emphasised the need to understand what Communism entails when trying to understand the psyche of people from Eastern European cultures. Their understanding of freedom, their mobility, extended social relationships, deep-rooted fear and choices play a part. The Czech nation scored high on the Uncertainty- Avoidance index indicating high anxiety, directness and less patience than their western counterparts (p.263). Similarly, Turkish identity and culture cannot be understood without understanding of Turkey’s imperial past and the process of modernization and westernization for the last 150 years which is marked with an ongoing tension between maintaining historical and cultural values and the traditional and religious values (Mardin, 2006).

Race, ethnicity, psychotherapy and research

Race and ethnicity are used interchangeably when referring to the groups of people who share similar physiological traits and psychological characteristics. They however differ in their meanings and emphasis in terms of the political and psychological (Lago, 2011). Considering counselling and psychotherapy, Lee (2001) argues that the concept of ethnicity has specific significance in that the psychological and personality characteristics of people become reinforced in time in society and it shapes their thinking, feeling and behaviour patterns. Ethnicity therefore involves shared social and cultural characteristics that have a bearing on psychological functioning (Zane et al., 2004).

Zane et.al. (2004) have suggested that ethnic minority research is difficult to conduct due to sampling problem, difficulties in devising cross- culturally valid measures as well as applying the

existing theories that define cultures. Cultural sensitivity has become increasingly important in psychotherapy research and practice. In response to the growing ethnic minority population and the increased demand for psychological services among minority clients, many therapists and researchers have attempted to identify competencies and guidelines for providing culturally sensitive approaches to treatment (White, Gibbons and Schamberger, 2006).

To really understand a cultural group, knowledge of cultural values and the history of racial/ethnic relations in that society are essential. It is important to explore the relationships between majority and minority groups. Lago and Thompson (1996; p.40) state that:

‘We cannot examine our own cultures without the assistance of ‘cultural outsiders’.

Clients from collectivist cultures value harmony among the members of their groups, tolerate their views and prefer indirect communication to minimize conflicts (Triandis, 1985) and people are integrated into strong, cohesive ‘in-groups’ (Motschnig and Nykl, 2011) whereas people from individualistic societies view the self independently from context (Rhee, Uleman, Lee & Roman, 1995). Church & Lonner (1998) added that those unique personal agencies are conceived as assertive, competitive, self-assured and self-efficient in the West. Watson & Protinsky (1988) argued that individualistically oriented psychotherapists may label a Latino family’s interdependence, for example, as enmeshment even though enmeshment is found to be positively correlated with a healthy ego development. Sahami-Martin (2009) suggests practitioners understand Iranian patients with two permeable categories when it comes to well-being: physical (bodily health) and spiritual (emotional health), arguing that the heart is the centre of emotion, therefore spiritual health is experienced in the heart and chest rather than in the head or brain, which leads to widespread somatization of the emotions.

Zane et al., (2004) note that any culturally driven psychotherapeutic interventions that include living the folkways or ancestral rituals would be well received by Latinos and American Indians. Likewise, Kakar (1982 p. 275) underlines the dominant difference between Western and Indian approaches to mental health, arguing that the main difference is their emphasis on a person’s behaviour in relation to others, especially family and community. Personality in the West is indivisible whereas it is divisible in Indian psyche. So, the ‘language of emotion’ in East Asian cultures is somewhat different, and metaphors are often used to communicate feelings Chang (1985).

In the UK, the prevalence of mental health problems in the general population is high with one in every six people having a mental health problem at some point in their life (Sainsbury Centre for Mental Health, 2007). Engaging with service users has resulted in mental health services changing

considerably over the past decades (Coppock & Lopton, 2000); community services have developed, asylums have been closed and mental health has become a National Health Service priority in England (Boardman, 2005). The BBC similarly reported that one in six working age adults suffer from mental health problems and it has become a major concern for the health services (Breakfast News, BBC, 26/10/2017).

In research on psychotherapy with ethnically diverse clients, utilization rates, premature treatment termination and length of treatment are commonly used as 'indirect' indices of outcome. These factors vary amongst groups. Greene, Richard and Roberts (2008) reported that black clients use the services less than white clients in the United Kingdom. A study with women immigrants in Amsterdam found that Surinamese, Antillean, Turkish and Moroccan women used mental health care services less than native born women. However, immigrant women consulted social work facilities and women crisis intervention centres nearly 1.5 times more than mental health care services (Crijnen, Bengi and Verhulst, 2000). Exploring the reason for the ethnic difference in service utilisation, Carta, Bernal, Hardoy and Haro-Abad (2005) argue that cultural and socioeconomic factors are largely responsible of such a difference.

Length of treatment is another indirect indicator of treatment outcome. In a depression study, Organista, Munoz and Gonzalez (1994) found that ethnic minority status was found to be associated with a high dropout rate. Taha & Cherti (2005) report that mental health problems amongst BME communities in Britain are associated with shame and stigma; that there was the fear of being labelled, isolated or alienated from friends or family members; that mental ill health was understood to be a sign of failure; and that psychological stress was associated with madness. Greene, Richard and Roberts (2008) add that BME members with mental health problems in England are often reluctant to use existing services because these are found to be culturally insensitive to their needs. An examination of studies of mental health services for migrant groups in Europe shows that quality and availability of service provision varies greatly between countries due to rapid economic and social changes that have taken place in some countries (Carta et al., 2005, Watters, 2002).

Counselling and psychotherapy with ethnically different clients

The ability to conduct therapy effectively with ethnically diverse populations is an important competence in terms of addressing inequalities (Bhui, Morgan 2007). It is challenging, and demand is increasing, as providing the right emotional support for people is a necessity for inclusive and effective mental health services.

Clients from certain cultures find counselling useful only if it is active, open and explicit and some cultures may not respond appropriately to reflective approaches (Triseliotis, 1986). A Western counsellor or therapist may then erroneously conclude that 'the person is repressed, inhibited and shy' (p.38) due to the reserve, restraint of strong feelings and subtleness in approaching problems (Sue, 1981). Any hesitance or distrust amongst Bosnians in the West can also be misunderstood unless 'Devastated Trust' (Mooren and Kleber, 2001) in them is acknowledged. Devastated Trust is the painful outcome of a bitter war during which not only their cultural and social infrastructure, but also their emotional and spiritual integrity was shattered. Asian-Americans show a lower tolerance of ambiguity than that their white counterparts, and tend to prefer structured situations and practical solutions to problems (Sue, 1981). Leong (1986) similarly reported that people from China and the Indian subcontinent might prefer 'a logical, rational and structured counselling approach'.

Conflicts in group counselling between the client and the therapists can also be exacerbated when the group leader is unaware of the cultural values of Asian Americans, for example, and expects 'equal' participation from them (Leong, 1986). Under such pressure, they either withdraw or terminate prematurely from the group. The main reason why Latinos, for example, underutilize mental health services was that they were encountered by Eurocentric-based services insensitive to their own cultural and spiritual experiences (Hall, 2001) in the USA. Lack of cultural sensitivity in clinicians (Sue & Sue, 1999) may lead to clients becoming suspicious of the techniques and goals of mainstream psychology (Ramirez, 1991; Comas-Diaz, 2006).

Cultural sensitivity involves therapists' willingness to address issues of race and ethnicity. African American women are more willing to reveal intimate information to female counsellors who address issues of being an African American woman than to those who avoid these issues (Zane et al. 2004). Black Americans find it more appropriate to seek help from family members or ministers of the church in dealing with the inner self (Smith, 1985a). D'Ardenne & Mahtani (1999) note that an effective counsellor has the responsibility for finding a shared language. Eleftheriadou (2003) argues that if a language gap exists, therapeutic work may not progress. There may not be equivalents in different languages.

Cultural influences affect people in many ways including in help seeking behaviour, their response to therapeutic interactions and potential outcomes (Lin,1989). In certain cultures, the detached introspection of talking therapy is an alien activity (Baluchi, 1999). Furnham & Bochner (1986) underline the importance of non-verbal behaviours. Geertz (1983, p.68) observed that the Moroccan cultural system offers its citizens 'contextualised selves' that link people to their ancestors, and the settings in which they grew (in McLeod, 1998; p. 167). In a study of mental health problems of Turkish and Kurdish communities in London, it is reported that people tend

to tell their problems in stories, describing them in indirect ways and expecting many subtle dynamics to be understood by the professionals (Derman Report, 2006).

Psychological treatments are thought of an essential part of comprehensive mental health services that are an integral part of the culture. Western mainstream psychotherapy promotes an ideal self that is unique and independent from others. Some normal behaviours of culturally diverse clients may be interpreted as resistance to treatment and even deviant (Chin, 1993). The therapeutic relationship can also be affected by bias of the therapist, generated by the in-professional training (Leong, 1986). Sue (1981) similarly argued that certain characteristics and assumptions may impose barriers to effective therapy such as class-bound values, strict adherence to time schedules, an unstructured approach to problems, and an emphasis on individuality, verbal and emotional expressiveness. A wide-ranging review of research and practice into mental health services for BME populations undertaken by the NIMHE found that the stigma associated with mental health problems can be made worse by racial discrimination, and that the access to appropriate assessment and treatment may thus be impaired (Sashidharan, 2003).

When working with clients from a different culture and language, it is also important to understand the background of that ethnic group within the host culture as the acculturation process itself can cause stress (Sue & Zane, 1987; Farsimadan, Khan and Draghi-Lorenz, 2011). Acculturation means to what extent members of an ethnic minority groups have learnt or adopted the cultural patterns of the majority group (Sue & Maroshima, 1982). Barry (2005) explains it as social interaction, and communication styles that individuals adopt when interacting with individuals from another culture. He also argues that acculturation includes competence and comfort in communicating with ethnic peers and members who are not from their own group, which goes beyond assessing English language fluency. His study with Arab male immigrants in the States showed that associations between acculturation and ethnic identity indicated the importance of assessing multiple facets or dimensions rather than using categorical or unidimensional measures of culture (Barry, 2005). A study carried out in randomly selected sample of Turkish immigrants, found a prevalence rate of "minor" psychiatric disorders (33.4%, 36.1% in females, 27.9% in males), higher than those normally found in community based samples. The results suggest that the expression of somatic complaints around "tightness" should alert physicians to further explore symptoms of minor psychiatric disorders and to examine sources of distress stemming from partner relationships, family, work and from poor housing and financial conditions (Veen, Selten, Hoek, Feller, van der Graaf and Kahn, 2002; Farsimadan, Khan and Draghi-Lorenz, 2011).

When offering any psychological and emotional help, ethnic matching can play a significant role. Yeh, Eastman & Cheung (1994) noted that ethnic matching has beneficial effects on treatment

utilization and outcome. For example, Russell, Fujino, Sue, Cheung and Snowden (1996) reported that African American clients who saw ethnically-matched therapists were judged to have better psychological functioning after treatment than those clients who were not matched with the same race therapists. Components of a cultural match include a shared language, understanding the client's cultural background and an openness to modifying treatment (McLeod, 1998). Cultural match and ethnic match are however not necessarily synonymous. Some therapist–client cultural matches are also ethnic matches but not all of them (Zane et al., 2004).

In cross-cultural therapy, the traditional theories of psychotherapy will inevitably be challenged; if the therapist does not have a theoretical model that can be adapted for cross-cultural work, the patient may fail to engage with or adhere to treatment. In some instances, rather than analytical, psychodynamic, and insight-oriented therapies, psycho-educational approaches would be more appropriate methods of choice. As Tseng (1999) concludes, the reason for being ineffective in existing psychological interventions may not be the miscommunication between therapist and client but theoretical and technical failures that can culminate in treatment failure. The assumption that psychotherapy can be culture-free or be applicable to all cultural groups is problematic (Jackson, 1990). Counselling may similarly be an unfamiliar concept for many who are not accustomed to discussing their intimate feelings with a stranger (Summer, 2005). This can be a sensitive issue, especially for men, when dealing with emotional difficulties (Scher, Stevens, Good and Eichenfield, 1987).

There are many complexities in ethnic minority counselling. Ethnic minority groups, particularly migrants, are faced with several potential barriers in the access of care, resulting in a lower representation in mental health services. Research from different countries in the Europe reported significant subjective and objective barriers in accessing services. The objective barriers lie in the domain of the available information, the structure of the health care system, or the availability of treatment modalities. The subjective barriers lie either on the side of the affected person, the treatment professionals or health care planners (Carta et al., 2005; Hansen, Yagdiran, Mass and Krausz (2000). To Nikelly (1997) another strategy would be to help communities identify with the host culture through historical and experiential exploration of differences and commonalities. Ethno-cultural assessment might be needed for assessing a person's ethno-cultural heritage, the family's adjustment in the host society, the individual's development as distinct from the rest of the family; and for a determination of areas of ethno-cultural overlap between the therapist and client (Jackson, 1983; Summer, 2005, Carta et al., 2005).

The nature of the triadic therapeutic relationship

Interpreting in a triadic framework is a dynamic process and each side has their own expectations and preferences. Having an interpreter can also make therapists feel observed or unduly scrutinized. The interpreter might be experienced by the clients as more powerful and experienced than the professional himself.¹⁰ Blackwell (2005) claims that clinicians might also project their own critical superego onto interpreters.

Interpreters too may have their own expectations and the need for their emotional states to be understood. Holmgren, Sondergaard and Elklit (2003) found that refugee interpreters reported tiredness, exhaustion, difficulty with concentration and sleeping, intrusive thoughts, crying, withdrawal from their family and several physical symptoms because of their work. Burck (2004) adds that some participants may prefer to use a second language rather than their mother tongue as that might be linked with negative past experiences (in Stevens & Holland, 2008).

When the roles are taken on appropriately, it helps to establish and strengthen the alliances between all parties involved. It is reported that good working alliances can be achieved when everyone feels heard, understood, valued and fully involved in the process (Kaufert & O'Neil, 1995; Kaufert, O'Neil, & Koolage, 1985), and a better outcome is more likely when conflict is reduced, and where a culturally sensitive assessment or suggested intervention makes sense to all (Dwivedi & Varma, 1996; Kaufert, 1990; Kitron, 1992; Rechtman, 1997). It is, hence, suggested that a client-interpreter relationship may begin prior to the client-therapist relationship to help the client to understand the idea of therapy (Miller et al., 2005; Fatahi, Mattsson, and J. & Skott, 2005; Fatahi et al., 2008). This can prevent clients from developing uncomfortable feelings towards interventions as they might come from a culture in which psychological services might be highly stigmatized. The therapists also need to explain the interventions and the theories that they will be using.

Triadic versus dyadic relationships

A dyadic therapeutic relationship consists of two individuals, usually a client/ patient and a provider/doctor/therapist (Haenel, 1997). Interpreting sessions traditionally take place

¹⁰ Spector, S, Briedis, J. & Rebori, V. The Triad of Interpreted Psychotherapy. Unpublished manuscript.

in assigned rooms as a triadic relationship containing three individuals: the client, the interpreter and the professional. However, this communication is regarded as a dyadic relationship, ignoring the third person, the interpreter.

Some authors suggest that the consistent and clear communication between the client and the therapist improves the outcome of therapy in terms of maintaining rapport (Hunt et al., 1985) and overall satisfaction (Dormaar, Dijkman, and de Vries, 1989). Herman (1998) found that despite the therapist's theoretical orientation, and regardless of the specific techniques employed in psychotherapy, the match between the therapist's and client's therapeutic approach will have significant implications for the outcome. Herman found this phenomenon occurred regardless of the therapist's being a student, or having years of experience.

This indicates a challenge for therapists working with non-English speaking clients because communication is halted by the translation process, and emotional attachment proves difficult to achieve. As Foon (1986) argued, the more similar the client-therapist dyad, the greater the likelihood of the communication being clear and readily understood. Therefore, establishing bonds in a triadic therapeutic relationship through an interpreter is a slow and challenging process.

Some authors have discussed the dynamics of dyadic exchanges where multiple languages are spoken. For example, Lee (1997) argued that the clinician, the interpreter, and the patient form a "therapeutic triad" with three interlocking sets of relationships, calling this structure a triangle with three sets of pairs, or dyads, each one of which is operative at a given point in time.' (p.4).

The power relationship within the triadic framework changes and affects individuals during the therapeutic process. The communication of emotional issues with clients who have limited English language skills is not easy and even subject to distortion (Bhui & Bhugra, 2004). But the complexity of the communication in exchanging cultural understanding and information is further increased when the third person joins in, leaving some parts unsatisfactory and some issues unexplored (ibid, 2004).

It is reported that in a triadic relationship, complex issues such as transference and counter- transference are more likely to occur. Having someone who speaks the client's own language present mediates therapeutic encounters and builds up the client's trust

(Saxtroph & Christiansen, 1991). However, the client-therapist bond is slower to form within a triadic encounter (Miller et al., 2005), and triadic communication becomes even more complex when a relative or a friend joins the consultation (Tribe, 1999) or when working with families (Fox & Gardner, 2004).

Complex emotional reactions

Client, therapist and interpreter form a relational system together. Each develops conscious and unconscious feelings, value judgements, thoughts and fantasies throughout the therapy. Moreover, all have their own assumptions, attitudes and expectations, which can become a major issue when working with people who cannot speak the language of the dominant culture. Miller et al. (2005) point out the factors distinguishing psychotherapy with refugees from psychotherapy with other clients who might not require an interpreter, emphasizing that refugees are likely to be subject to political persecution, torture and violence, as well as to have multiple experiences of loss (p. 27). Furthermore, refugees survive immense deprivation (Tribe & Morrissey, 2004) and are forced into making decisions with life changing implications. Also, their experiences of multiple losses include not only loved ones, but also social networks, colleagues and valued social roles (Kinzie, Sack, Angell, Clark and Ben, 1989).

Although there is no substantial evidence reporting non-English speaking clients' experiences of the therapeutic and interpreting process with both counsellors and interpreters, both interpreters' and counsellors' experiences of triadic relationships with non-English speaking clients is well documented (Century, Leavey & Payne, 2007; Stevens & Holland, 2008; Miller et al., 2005; Bjorn, 2005). The cause of this inconsistency is perhaps the difficulty in exploring the non-English speaking clients' experiences and feelings due to language and translation issues. It can be claimed that the triad can be best understood when all three members are worked with, and their experiences explored.

Various studies for example report that clients feel better with the presence of an interpreter (Holder, 2002); feel understood (Kline, Acosta, Johnson, & Austin, 1980); have a high attendance rate (Hillier et al., 1994) and recount more past traumatic experiences (Bischoff, Bovier, Rrustemi, Gariazzo, Eytan and Loutan, 2003). This suggests that interpreters should be cared for if the therapist is to create a caring and

comfortable working environment, as they may be stressed and traumatized by what they hear. Surely, listening and processing stories of human suffering will have an impact on one's emotional well-being. Moreover, interpreters may experience transference towards their clients, and this will affect their impartiality (Miller et al., 2005).

Many factors cause interpreters to feel uneasy and confused about their roles. These factors range from client-related issues to the triadic therapeutic relationship itself. Some interpreters have reported that they found staff attitudes restrictive and patronizing, leaving them feeling excluded from the primary care team and creating conflict between their self-image and the experienced reality (Fatahi, Mattsson and Skott, 2005); they sometimes get upset by and worried about what to interpret, and they experience mood or behavioural changes lasting from a few hours to several days (Valero-Garcés, 2005). Thus, due to the dynamics of a therapeutic relationship, interpreters are affected by developing counter-transference reactions, and feel devalued or over-valued throughout the process; experience helplessness, anxiety, powerlessness, anger, guilt and feelings of failure (Haenel, 1997).

There is no doubt that not only interpreters but also therapists feel unease, confusion, and even helplessness in the face of the diverse and complex stories of their clients. Interpreters can influence feelings and attitudes of therapists throughout the therapeutic alliance in which therapists are responsible for the well-being of the other two (Fox & Gardner, 2004).

Miller et al. (2005) have reported that therapists are now more appreciative of interpreters' contributions than before, but that they are stressed by aspects of the interpreters' ways of working, such as omitting or adding to what was said. They also feel more self-conscious in the interpreter's presence. Kaufert & Koolage (1984) added that therapists felt hostile when interpreters went beyond their remit. Burchell (2009) understands the therapists' feelings of depression and trauma as a 'secondary trauma'; a form of 'negative counter-transference'. Therapists can experience similar physical responses to those of the client such as anger, helplessness and even antagonism towards the client (ibid, p.7). They can develop transference and experience nightmares, anxiety, depression and paranoid ideas. This may indicate that they are too close to their clients (Miller et al., 2005).

The therapeutic alliance is a working relationship that Miller et al. (2005) refer to as ‘positive, collaborative relationship based on trust and a shared commitment to the client’s growth and healing’ (p. 29). However, once the interpreter joins the team, the traditional dyadic relationship tends to break down as the third party brings their own expectations, understanding of emotional states and varying linguistic skills (Bhui & Morgan, 2007). The authors have also argued that if both are not attuned enough, the interpretations of the past and the present, disclosure of intimate traumas and highly sensitive aspects of self may be jeopardized (ibid, 2007; p.190).

Some therapists regard interpreters as ‘invisible members of the team’, an ‘unfortunate necessity’ and an ‘obstacle’ to therapeutic contact with the client (Miller et al., 2005; p. 30). Despite these challenges, however, most therapists view the interpreter’s role in more relational terms, so that the interpreter is regarded as an integral part of a three-person alliance (ibid, 2005); and as someone who witnesses the client’s story, increasing the trust within the triad (Fox & Gardner, 2004).

Overall, the available research, although limited, suggests that when health professionals regard interpreters as cultural experts and involve interpreters in the clinical process, the therapeutic relationship and the outcome tend to improve.

Factors affecting therapeutic relationship

Power, knowledge, life experiences, dependency, emotional responses, training and therapeutic process are important to consider in any therapeutic relationship as each has an impact on the quality of communication and working alliances. Raval (2005, p.201) notes:

‘...the likelihood of conflict is greater when powerful feelings remain unacknowledged or cannot be spoken about. Many interpreters do not have access to any formal support or regular supervision to help them manage the personal distress that often arises out of their work. However, practitioners can support interpreters in processing such emotional distress or vicarious trauma by building in shared reflective practice as a routine component of their work together.’

Bhui & Morgan (2007) recommended that therapists in establishing culturally capable psychotherapy should know more about race and ethnicity, power relations and culture within the society, becoming a 'mini ethnographer'; that they should think critically about their own understanding of race and ethnicity, and their impact on their practice (adapted from Cardemil & Battle, 2003). Stevens and Holland (2008) looked at the experiences of therapists working across languages. They identified five fragmenting factors that threaten therapeutic relationships, and five integrating factors that strength therapeutic relationships. They argued that fragmenting factors in a cross-lingual therapeutic relationship may result from the therapist, the client and the outside world. They have divided the fragmenting factors into five sub-categories:

- blocks that lead to the loss of psychological contact (e.g. accents, 'mamma mia' moments etc.).
- uncertainties that cause therapists to question themselves and the process e.g. the effectiveness of intervention used.
- apprehension that leads to negative inner process for therapists, e.g. self-doubt
- unknowns causing unanticipated breaks in the relationship (what the therapist is unaware of, such as her sense of white racial identity. McIntosh (1998) terms this the 'invisible package of unearned assets').
- other differences (language gap and culture, class, religion and so forth) (p.23)

Similarly, they further subdivided integrating factors into 5 groups:

- the therapist's view of the relationship and his/her perceptions (e.g. collaboration)
- the therapist's view of the client (awareness of client's situation and inner process)
- the therapist's own experiences of difference (being/living in another culture)
- the therapist's view of understanding (simply checking if the client understands the therapist)

- the rewards the therapist derives from the work: taking the whole process as a challenge; regarding it as ‘an add-on’; swapping a slower pace for a more reflective practice and achieving parallel thinking (p. 23).

D'Ardenne & Mahtani (1999) note that all clients experience both internal and external changes in their lives, and they should change or adapt their thoughts, feelings, attitudes to what has been happening around them. They may have to change their relationships, or personal circumstances due to external forces. Therefore, in working with clients from different cultures, the external forces and environment around them should be fully addressed, because these experiences within a totally different culture are likely to create a chronic sense of ‘loss’.

Holmgren et al. (2003, p.26) reported that the interpreters they interviewed had used certain strategies to cope with the stress that arise in their work with traumatized refugees as below:

- detachment: cognitive withdrawal from the situation.
- self-control: regulation of feelings and actions.
- flight-avoidance: wishful thinking and behavioural efforts to avoid thoughts and feelings.
- social support: seeking information and emotional support.

Further research is needed to explore these issues in detail by taking broader approaches as the mental stress may stem from being a refugee, going through an acculturation process; from being an interpreter coming from similar background to that of the clients or just hearing and processing terrifying stories of another human being in an emotional setting.

Immigration, communication and mental health

In this section, immigration in the British context and its impact on services will be described. Then factors impacting on mental health and therapeutic encounters will be explored through the lens of language and its associated power. Finally, the importance of communication in mental health will be discussed.

Immigration and mental health

Britain has, historically, been proud of being open to newcomers and appreciative of their contribution in many spheres of society. The 2011 Census has shown that England and Wales have become more ethnically diverse, with minority ethnic groups continuing to rise since 1991; one in five people (19.5% of the population overall) identified with an ethnic minority group.¹¹ According to the census, 87% of the population (48.6 million people) was born in the UK and 13% of the population (7.5 million people) was born outside of the UK. Amongst the 56 million residents in England and Wales, 86% were White, 8% were Asian/Asian British and 3% were Black/African/Caribbean/Black British. Of the foreign-born population almost half (46%) identified as White, including over a quarter who identified as Other White (28%).¹² Almost one million people born abroad (13% of the foreign-born) identified as White British and a further 354,000 (5% of the foreign-born) identified as Irish. One third of the foreign-born identified as Asian (33%) and 13% as Black/African/Caribbean/Black British.¹²

People emigrate for a variety of complex reasons ranging from internal unrest, persecution by their own government for their ethnic identity or faith (Tribe, 2002), to unemployment and poverty (Fatahi et al., 2008). Evidence from the 2011 census shows similar patterns of economic activity that vary widely across different ethnic minority groups within the UK with some groups experiencing lower employment and higher inactivity rates¹³. Immigration is bound to increase as the conflicts around the world increase (Bruntland, 2000). Although political refugees who have been persecuted and displaced have always existed, they have attracted specific national and international legal

¹¹ <https://www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/ethnicity/articles/ethnicityandthelabourmarket2011censusenglandandwales/2014-11-13>

¹² <http://webarchive.nationalarchives.gov.uk/20160106070721/>

¹³ http://www.ons.gov.uk/ons/dcp171776_407038.pdf

concern only during the 20th century (Lambert, 1995). The United Nations High Commissioner for Refugees (UNHCR, 1951: p.5) describes a refugee as:

‘...someone who is unable or unwilling to return to their country of origin owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership in a particular social group or political opinion.’

A refugee is someone who has obtained the right of permanent residency and has rightful access to public funds (Tribe, 2002; p. 241). Their mobility is flexible and free. ‘Asylum seeker’ is a legal term referring to someone awaiting legal permission from the Home Office for permanent residency in the UK. They can be living in the country for ten years without a permanent residency and without being able to easily leave the country.

The migrant population in Britain is diverse and includes economic migrants including for the EU. Their access to services and their utilization of the services are still limited if not poor as in the case of people from the Eastern European countries. Regardless of the status, moving to a new country is a stressful journey even if made by choice. Forced migration brings many challenges. The daily lives of people deteriorate when dealing with multiple emotional, social and physical problems without the support of loved ones (Tribe, 1999). ‘Diverse Minds’, set up in 1997, has been working to raise awareness of the difficulties that these communities face, (MIND, 2009; p.9):

‘While an asylum-seeker is awaiting their leave to remain, the process and the waiting are unavoidable obstacles over which they have no control. No plans can be made until a positive decision on an asylum-seeker’s claim is given. He or she cannot find a home of their choosing, they cannot seek employment, cannot go to university, cannot make concrete plans for their or their children’s future, and cannot begin to deal with the past...’

Offering right services to these individuals and communities has always been challenging for the authorities due to the inherent diversity within it. It has been an evolving process. BME communities in general have been critical of their experiences of mental healthcare in Britain. The ‘Improving Access to Psychological Therapies’ scheme (IAPT, 2007, 2009) indicates that there is a growing concern regarding mental health issues amongst

the minority communities in the UK and these communities include both established ethnic minority groups and newly arrived asylum seekers. For example, in an audit of the mental health of asylum seekers and refugees, Palmer and Ward (2005) found that only a small number of specialist organisations outside the National Health Services provided culturally appropriate services to this group. A recent evaluation report shows that the current 50% recovery target for patients treated under IAPT is not being reached, and that there were significant associations between socioeconomic deprivation and psychological therapy outcomes (Delgadillo, Asaria, Ali and Gilbody, 2016). More varied options in emotional support should be offered (Vertovec, 2006) and more funding should be given to the services working in deprived areas. This funding should match the increased psychiatric morbidity and disadvantages of their local populations (Delgadillo et al., 2016).

Sue et al. (1982) note that despite improvements, ‘the human service professions, including counselling and clinical psychology’, have not delivered the needed services to ethnic minority communities. Summerfield (2001) argues that mental health services aim to offer morally and politically neutral technologies and services; however, these services may not necessarily be well-equipped to address diverse human suffering. Although there have been many improvements in developing culturally sensitive and inclusive services, there is still much to do.

Language and power

The Oxford Dictionary and Thesaurus (2001, p.423) defines language as

‘the use of words in an agreed way as means of human communication’; ‘the system of words of a particular community, country etc...’, and the ‘faculty of speech’.

Language is everything for individuals and communities, and covers all sorts of relationships, symbols, behaviours and practices, which are passed from generation to generation. Languages act like vehicles in achieving communication with others, carrying messages and symbols. Wetherell & Maybin (1996) add that languages do not only provide practical meanings but are also abstract systems consisting of ‘vocabulary, grammar, semantics and syntax (p. 239). They are also seen as a form of social action and a process of communication, using the term ‘discourse’ to refer to actual talks, writings,

texts and even practices (Fairclough, 2001; Wetherell & Maybin, 1996). These human linguistic practices and discourses change depending on the context in which conversations or relationships take place (for instance, a discourse in court would contain different elements from a discourse in a hospital), and on the relationships between individuals. People will adopt different styles or accents when communicating with others. Gender is also a factor. Cornwell (1984) found that women used different language when they talked to their neighbours about their illnesses, which she called 'private accounts' of illness. However, women used 'public accounts' of illness when they had to justify their position as a mother.

Language has an impact on a person's identity and power, providing roadmaps to people and opening to new opportunities, especially when the language of the host culture is spoken (Anzaldúa, 2004). Miller & Miller (1996) have pointed out the complex relationships between language, identity and self-determination, using the example that the power that Catalans exerted in economic and educational fields in Spain has had a great impact on Spanish language-related policies, including the development of radical language normalisation programmes (p.24). Language is closely related to identity in that the way a person speaks or writes reflects the social status and even power of that person. It is noticeable that people from working class, middle-class (Wetherell & Maybin, 1996), or colonial backgrounds (Bernstein, 1971) use language with different intonations that affect the power they wield in society.

Regarding the relationship between power and language, it was reported that colonial officials did not allow slaves to learn how to read and write as they were scared it would lead to a strong rebellion against the masters and their exploitation. They tended to separate slaves from the people that spoke the same language to disallow their potential mutual support (Anzaldúa, 2004). The power that people exert on others depends on many factors, including gender, social class, ethnicity, age and social background. As McLeod (2000) explains colonial racism and the oppression of black people can be understood through the ideologies of that time, and, also by the religious beliefs and economic structures in place within Europe and North America (p.240).

Language establishes a vital driving force in the process of integrating into society (Wren, 2004). In relation to newcomers, people whose linguistic proficiency in English is not enough to communicate encounter challenges both in integrating into the host community

and accessing the available mental health support (MIND, 2009). Stereotypes imposed by individuals of higher social status onto ethnic minority people (for example, classifying Black men as 'aggressive' and Irish 'alcoholics'), lead to unfair and oppressive treatments (Sashidharan, 2001). These incidents cause discomfort in other members of the community, leading to invisible barriers in accessing required health services (Greene, Pugh & Roberts, 2008).

In a multicultural society, encounters with people who differ in their conceptualization of mental health are likely; talking therapies as isolated inner journeys may not be a known practice for some (Baluchi, 1999). It cannot be argued that other cultures do not question themselves, but can be acknowledged that they might not question themselves with professionals whom they do not feel close enough. One of the service users in a study explains ('Unheard Voices' in Palmer & Ward, 2005; p. 42);

'Counselling and talking therapies are not part of our culture. If we have emotional or personal problems, it is not part of our culture to talk to a strange or professional. When you are talking about mental illness and mental health in the UK context these are two separate issues but in our culture, they are one.'

In broader terms, service users from certain BME communities whether it be established such as Irish or black communities or a newly established one such as the Bosnian community stated that their needs and ethnic background were not reflected in mental health assessments. People from the BME communities have reduced life expectancy and have greater problems with access to health care than the majority white population (NIMHE, 2003). After the death of David Bennett, who was held in a secure unit under the Mental Health Act, the Department of Health published new objectives and recommendations in the Inside/Outside report (Sashidharan, 2003), aiming to offer improved mental health services by reducing and eliminating inequalities, developing the cultural capacity of the services, and engaging with the community. The government also published 'Delivering Race Equality: A Framework for Action' (Department of Health, 2003, 2005) in response to community consultation, with greater emphasis on further community engagement towards tailored planning, commissioning and delivery of services.

Communication and mental health

The main difficulty in a therapeutic client-provider relationship with people whose English proficiency is limited is communication. Language barriers to accessing services have been widely reported and these barriers are complicated by ethnic minority status, and by the diagnosis and disability that these people had suffered in their country of origin before migrating (NIMHE, 2004).

Language is a multifaceted and complex phenomenon (BPS, 2008), and languages act like mediators that help to establish the ways of structuring reality (MacLachlan, 2006). Languages may not always be interchangeable and words in one language might not exist in another (Anderson & Goolishian, 1992).

Some mental health services use interpreters. Interpreters always constitute a triadic conversation in which they facilitate communication, or what Holder (2002) calls a 'mediated or processed communication'. Interpreters are needed for non-English speaking clients who cannot speak English confidently. One might expect that lack of communication will not only hinder the appropriate services or interventions but also, as Tribe & Morrissey (2004) state, that it might exacerbate feelings related to displacement, resulting in fewer attendance at the clinics, dissatisfaction with the staff, and reduced adherence to the interventions. A report published by MIND ('A Civilised Society', 2009) further reported that the quality and availability of face-to-face interpreting services across England and Wales varied (p.2) and that many mainstream staff lack skills in working with face-to-face interpreters and using telephone-interpreting services (p.13).

Facilitating communication between clients and healthcare providers entails more than transmitting information between them. It is possible for an interpreter to shorten or lengthen conversations, omitting or adding some parts to what was said. They should be able to coordinate the communication in such a way that the involved parties can negotiate their communicative goals and identities (Baker, Haynes & Fortier, 1998). The interpreter's bilingual and bicultural position can broaden patients' and therapists' understanding of communication (Hudelson, 2005). Professionals are expected to educate themselves about potential cross-cultural barriers and develop the skills necessary to avoid the adverse effects of poor communication.

Further perspectives in interpreting

This section will detail different types, models and practices of interpreting that have been used in different contexts and by different industries.

Modes of Interpreting

It would be difficult for ordinary people to realize the complexity of the interpreting profession. There has been a longstanding debate as to which type of interpreting suits certain needs of diverse clientele. Today, a variety of styles of interpreting has been actively used, depending on the needs of the clients as well as the skills and expertise of the interpreters. One of the NAJIT (National Association of Judiciary Interpreters & Translators; (2006; p.2). position papers summarised the complexity of interpreting for the court settings as below:

‘Certified court interpreters are highly trained individuals who are, in many ways, the “invisible hand” of justice. They are expected to be nearly invisible in the courtroom yet must maintain acute mental presence at all times.’

The National Council of Interpreting in Health Care (2009; p. 9-11) listed most widely used interpreting modes as below:

Face-to-Face interpreting

The Interpreter is present during the conversation. This is often referred to as the “gold standard” in interpreting, as it offers the interpreter more control over the session and eliminates the unavoidable distractions that phone and video interpreters encounter. It is mostly effective when multiple persons are involved.

The common challenges for this method are: that face-to-face interpreting cannot always be accessed upon demand. Interpreters who are not employed as staff of a health care facility/provider must travel back and forth to appointments, creating waiting times in emergency situations; that face-to-face interpreters must address the same health and safety risks attendant to other staff in the facility; that face-to-face interpreters, who are

not afforded the degree of anonymity of telephone and video interpreters, often face ethical dilemmas (NCIHC, 2009; p. 9-11).

Remote interpreting by phone

Interpreters may be available via telephone. Quick and easy to access, telephone interpreting is mostly available through third-party vendors referred to as OPI (over the phone interpreting) providers. Some large hospitals and health systems have created internal phone banks staffed with in-house interpreters (NCIHC, 2009). It is mostly effective in telephone conversations, emergencies and in situation in which face-to-face interpreters are in limited supply or have limited availability.

The common challenges in this mode is that telephone interpreters are susceptible to the same environmental challenge people face when using the phone—echoes, feedback, static, etc. Frequently, providers utilize a speakerphone to communicate. This can create hearing issues for the interpreter. Individuals with a hearing impairment may face challenges utilizing a phone interpreter (ibid, 2009; p. 9-11).

Consecutive interpreting

Consecutive interpreting utilizes turn-taking as a mean to facilitate communication. The interpreter waits for natural pauses in the conversation during consecutive interpreting to render an accurate interpretation. The interpreter may interrupt the speaker after a few sentences to interpret what has been said before allowing the speaker to continue. It works most effectively during conversations in which there are natural pauses between sentences. Health care often consists of a string of question and answer sessions which makes this the most easily implemented mode.

The effectiveness of an interpreter's consecutive interpretation depends on his or her memory. Because the interpreter must listen to a critical amount of information before interpreting, they have to memorize and then interpret. The interpreter must also manage the flow of the conversation, which can be challenging when working with two or more individuals with distinct personalities and communication styles (NCIHC, 2009; p. 9-11).

Simultaneous interpreting

This occurs when the interpreter begins message conversion before the speaker finishes speaking and then delivers the same message at almost the same time. Simultaneous interpreting can be delivered either with specialized audio equipment (allowing the interpreter to be remote) or in-person using a whisper technique referred to as chuchotage. It requires intense concentration and can lead to interpreter fatigue. It is mostly used in conference settings where simultaneous interpreters work in pairs and switch off every 20-30 minutes in order to rest.

Simultaneous interpreting is also used during mental health encounters in which the provider may not want to interrupt the patient's message. It is effective where not everyone requires the interpreter. The interpreter can move closer to the client/patient and interpret to him/her only without interrupting the speakers (NCIHC, 2009; p. 9-11).

Summarization interpreting

The interpreter picks out the main ideas of a message and omits details. Due to the delicate nature of health care and the heightened importance of the details, this mode of interpreting is rarely recommended. In a situation in which a provider may be trying to get general information transmitted quickly, the interpreter, with the approval of the provider, may help the situation by summarizing the discourse of the family members. When summarizing, the interpreter may inadvertently omit some of these important details, possibly interfering with the provider's ability to make informed decisions. The interpreter makes the decision to identify details he/she feels important and/or relevant (NCIHC, 2009; p. 9-11).

Sight translation

Interpreters sight translate by reading a document in one language and delivering an oral rendition of the text in the target language. Sight translation is most effective with short texts such as forms and instructions. Other documents, such as consent forms or educational materials, should be translated ahead of time or summarized by the provider. The interpreter can then interpret what the provider says.

Sight translation is challenging because it requires the interpreter to both read and speak in different languages. This can be difficult for less experienced interpreters, who will often read and interpret one word at a time. Experienced interpreters read and interpret phrase by phrase (NCIHC, 2009; p. 9-11).

Models of Interpreting

This refers to the styles in which interpreters perform their jobs. These styles have been historically informed by the culture and the requirements of the concerned institution or the context. For example, the British Psychological Society has outlined these practices for the mental health field. BPS's guideline (2008) describe four different models of interpreting for mental health professionals working with interpreters, and these can be chosen before starting the sessions, depending on the mental health professionals' and interpreters' working style.

Each has its own merits with some clients in certain settings, for instance, for a court room interpreting, perhaps the linguistic mode can be the best option whereas for mental health encounters the psychotherapeutic mode would be more suitable (Tribe & Morrissey, 2004).

Linguistic model

This is also called 'word-for-word' interpreting. It is a conduit type of interpreting in which the expected role for the interpreter is to transfer the message to the other party. The interpreter takes a neutral and distant position, showing no emotions nor adding any further information or comment to what was said (Cushing, 2003; Tribe, 1998a).

The Psychotherapeutic or Constructionist model

The interpreter focuses on mainly the meanings of the words but only not passing the message through. The meaning will be given even if it includes adding more words to that message and cutting out some of it (Tribe, 1999; Raval, 2003). There is some concern that this mode can jeopardize the neutrality of the encounter (Avery, 2001).

The Advocate or Community Interpreter model

Interpreters take an active role and offer his/her advocacy to the client when needed. This service can be offered to the client both individually and organizationally (Drennan & Swartz, 1999; Baylav, 2003; Razban, 2003).

Cultural Broker / Bicultural Worker model

In mental health care, the term “culture broker” was introduced to develop a community mental health programme for the inner-city population in the USA to train participants to work within transcultural perspectives when working with patients from multiethnic backgrounds. The term “culture broker” was adopted to describe an intermediary who worked with therapists from the mainstream culture and clients from a different culture (Miklavcic & LeBlanc, 2014; p.120). Singh, McKay, & Singh (1999; p.5) note that a culture broker’s main responsibility is to provide a thorough “knowledge of mental illness as conceived and perceived by the individual seeking the services as well as by the mainstream culture”.

Different definitions of cultural brokering have evolved over time. Another definition states that cultural brokering is the act of bridging, linking, or mediating between groups or persons of different cultural backgrounds to reduce conflict or produce change (Jezewski, 1990). The interpreter offers further information about the client’s background and culture to the health care professional as a guide, a mediator or as a catalyst (Tribe, 1998a; Drennan & Swartz, 1999). This can enrich the mental health professionals’ way of working and competence in working with cultures (BPS, 2008). It is also thought as an important medium in the process of eliminating racial and ethnic disparities in health (National Centre for Cultural Competence, NCCC, 2004).

Further approaches to communication

Communication is a learned skill and people are born with the ability to talk. Communication focuses on how people use messages to generate meanings within and across various contexts, cultures and channels. Communication is also an academic discipline, embracing a large body of study and knowledge. The history of communication is full of accomplishment (Friedrich, 1991).

Communication theory is described as a millennium old accretion of different approaches to the problems of human interaction in private and public contexts (Farrel, 1993). The field of communication theory can offer an improbable number of alternatives and complements to the transmission model for the formulation of interpreting practice (Dysart-Gale, 2005). He suggested that rather than examining discrete theories, those theorizing interpreter practice may find more guidance when viewing communication theories as falling into one of two families below:

Peters (1999) characterised those two groups of theories for communication as Technical and Therapeutic. The technical approach includes the transmission model and seeks to improve communication through the optimization of technologies and techniques. In contrast, the therapeutic approach is regarded as means by which individuals realize their full potential within both themselves and society (Dysart-Gale, 2005).

Carey (1992) further offered two conceptualizations of Communication theory:

The Transmission View accepts communication as a movement of information. Ritual View, on the other hand, like the Therapeutic View, sees communication as a symbolic process whereby reality is produced, maintained, repaired and transformed. The purpose of Ritualistic communication is not to inform but to confirm the beliefs of the group and the ideals of the community.

These views are regarded as complementary rather than competing, creating new avenues for the development of interpreter theory. However, it seems that the popularity of the Transmission model will remain strong as it is widely used and has clear guidance to apply in interpreting. However, it must be stressed that the two views are not dichotomous. As Craig (1999) suggests, they can be approached as meta-models. Each approach offers 'distinct ways of conceptualizing and discussing communicative problems and practices'. For interpreter practice, this perspective suggests that there is no need to subsume the conduit role and interactive roles of an advocate, clarifier and cultural broker under the idealizations of the Transmission model. The range of behaviour required of actual interpreter practice is so broad, it seems to be unreasonable to suggest that sole reliance on one type of communication strategy or one theory of communication could be adequate to cover all situations faced daily (Dysart-Gale, 2005).

In recent years, there has been an increased interest in Ritualistic or Therapeutic conceptualizations of communication theory. These changes are apparent in the ‘narrative turn’ in medicine (Charon, 2001). Narrative Turn focuses on the negotiation of shared meaning and mutual understanding between doctors and patients. The narrative-based ethics replaces medical decision making based on abstract principles with a process of examining individual needs and local contingencies (Murray, 1997; Noddings, 1984). These scholars warn that the understanding of health communication processes is hampered by the usage of oversimplified communicative models such as conduit model. However, it is also argued that these models tend to ignore the process of creating meaning or the creation of a relationship through communication (Charon, 2001).

Theoretical background in interpreting

In this section, the difference between interpreting and translation will be explained, then the dialogical aspects of interpreting with the historical division in practice will be explored. The section will then discuss the modes of interpreting and the professionalization issues in the field.

Interpreting and translation

Interpreting is a communication with a mediator and its function is to allow communication between two parties (Avery, 2001). It involves a typical human interaction in which interpreters can read into their clients’ speech, gestures and body language. Most definitions of interpreting focus on the oral aspect of interpreting which is now regarded as a distinct profession in the modern world and has a well-established place in the fields of diplomacy, justice and international conferencing (Avery, 2001). The National Standard Guide for Language Interpretation Services (2007, p.1) describes it as follow:

‘Interpreting is the process of understanding and analyzing a spoken or signed message and re-expressing that message faithfully, accurately and objectively in another language, taking the cultural and social context into account.’

The definition of the National Council on Interpreting in Health Care (NCIHC, 2009, p.16) is as below:

‘Interpreting involves the oral rendition of spoken or signed communication from one language into another’.

Interpreting is seen to be used interchangeably with translation as both share certain commonalities such as the requirement of being fluent in both languages, of being competent in two cultures and having a good memory and so forth. But there are differences between the two fields in terms of the end-product and of theoretical and operational aspects. Interpreters will try several functions and roles to facilitate communication between clients and service-providers. To achieve that, interpreters use a variety of modes of interpreting, depending on the setting, such as a health clinic or a court room where different modes of interpreting work best, for example a conduit model would fit into court room interpreting whereas a culture broker role would be appropriate for health care interpreting.

Pöchhacker (2004, p.11) defines interpreting in a way that accommodates different types of interpreting rather than focusing only oral aspects of it:

‘Interpreting is a form of translation in which a first and final rendition in another language is produced on the basis of a one-time presentation of an utterance in a source language.’

Translation mainly refers to converting a written text from one language into another (Herndon & Joyce, 2004). A translator takes the message of the original text and renders it for its intended audience, maintaining the tone, register (level of formality), cultural context and the impact of the original text. Therefore, the most challenging task for the translator is to maintain the same cultural context with the same meaning in the target language (NCIHC, 2009). The main differences between interpreting and translation lie in the end product, training and skills (NCIHC, 2009). Some of them include the following:

The key skills of the translator are the ability to understand the source language and the culture of the country where the text originated, and, using a good library of dictionaries and reference materials, render that material into the target language. ¹⁴ An interpreter

¹⁴ Language Scientific: ‘What does an interpreter do?’ http://world.std.com/~ric/what_is_int.html

should be able to translate in both directions, without the use of any dictionaries, on the spot (NCIHC, 2009).

Interpreters work 'in the moment' bi-directionally and are compelled by the mode of interpreting; professional translators work mostly in only one direction, translating only into their native language (NCIHC, 2009).

Interpreters work in triadic frameworks even if interpreting is done over the phone; but translators work alone or in highly advanced translating teams. Translators also work in different timeframes, focusing on text analysis, conversion, proofreading and editing (NCIHC, 2009).

Interpreting will be further explored in terms of its development in the following section.

Dialogue interpreting and the early dichotomy

Dialogue is a critical tool to negotiate a diagnosis and treatment plan, and health care interpreting is a dialogic one and occurs at interpersonal level (Avery, 2001). Wadensjö (2001, 2004) similarly argued that communicative events are characterised by meanings that are in the process of being established between the subjects in specific socio-cultural situations within a dialogical theoretical framework. His model puts forward the interpreter-in-context but not the individual interpreter (Wadensjö, 1992; 1998).

Following the Dialogical approach, communicative activities carried out in hospitals, police stations, business negotiations and other socio-cultural settings are subject to ritualised norms and rules. The impact of the institutional frames on the interaction is very clear (Roy, 2000). The representative of the institution is by definition in control of how topics are selected, of how much and how often clients/patients are expected to talk, and how their contribution will be evaluated (Drew, 1992). Wadensjö (2004) argues that in interpreter-mediated institutional interaction, the person in charge may have to lose some of his control, and the interpreter willingly or unwillingly ends up taking further responsibility for the substance and the progress of the talk. Studies show that interpreters are given by the client or have imposed on them by the situation, some sort of responsibility of maintaining conversation that can underpin the power struggle (Miller et al., 2005) between interpreters and health professionals. This seems to be inevitable in a triadic relationship in which the therapist may feel less in control (Dubus, 2009).

In a Dialogical theoretical approach, one of the main cornerstones is the embodiment of the spoken language. It means that there is a need to highlight participants' bodily orientation, gestures and gaze. Wadensjö (2004) asserts that interpreters' utterances simultaneously serve two main functions: translation and coordination. He argues that interpreters' utterances achieve communication, connecting and coordinating others' utterances. Interpreters performing in interaction are dependent on the others' immediate assessment of what they do to continue (promoting, stopping or re-orienting the joint activity and vice versa) (Hsieh, 2004).

Health care providers historically idealised a neutral interpreting, in that interpreters act like a translation box (Hsieh, 2004) or a blank slate (Brunson & Lawrence, 2002), without showing any emotion, without adding or omitting anything. Since interpreting in health care has multiple aspects due to the nature of the relationship, settings, clients and service providers, it is not as strict as interpreting in court rooms where proceedings are predetermined and everyone has certain rules to obey. However, to Avery (2001), conduit or neutral interpreting serves the desire of maintaining the power on provider's side, freezing the involvement of the interpreter.

The Neutral versus the Active Interpreter

There are two perspectives on interpreters, the Neutral interpreter and the Active interpreter:

The Neutral Interpreter perspective asserts that the only responsibility of interpreters is to provide accurate and complete transmission of messages conveyed in one language into another language. Interpreters are expected to maintain a passive role and a disengaged presence while in fact they are very active and responsive. The analogy is made between being an interpreter and a bridge on which only spoken words should pass. This simplified definition of interpreting has been regarded as problematic because it limits the responsibility of the interpreter to the linguistic aspects of communication. It is also argued that the interpreter is not the person who can decide what is brought across the bridge; it is not his/her job to provide the cultural explanations. Therefore, the provider must be very clear in order not to create a need for further explanations (Avery, 2001).

The opposite perspective is the Active Interpreter view which asserts that interpreters are not regarded as 'message passers' but as professionals who hold a variety of

responsibilities. Contrary to the expectation of disengagement, the interpreter is recognised as a person who is part of and has some knowledge of the patient's cultural context which is unknown to the provider (Avery, 2001). Using this model, interpreters would be open to multiple aspects and roles within a given setting.

The Active role creates more space for interpreters to intervene when working with cultural factors. Since the role is active, the interpreter has the legitimate option of alerting parties to miscommunication. Under this frame, the interpreter can be regarded as the manager of the cross-cultural mediated clinical encounter. In this sense, her/his social presence is accepted as legitimate. The interpreter accomplishes the development of shared meaning by providing the appropriate linguistic conversion from one language into another, and actively assisting in overcoming barriers to communication embedded in culture, class, religious and other social differences (Avery, 2001).

The Active interpreter model recognizes the ongoing change in the dynamics of power between the parties when the third party joins the dyad. Only the interpreter has access to the other two parties' social worlds, and the interpreter holds the power of information in the interest of the health care goal. His or her main goals are to maintain the flow of communication, keep the focus of communication between the provider and the patient, and intervene when necessary to flag up cultural barriers to communication (Avery, 2001).

In this wider perspective role, the interpreter is likely to perform various roles, depending on the need of the health care provider and the institution. These roles involve being a 'communication advocate' or a 'referral advocate' (Avery, 2001). This calls for an umbrella type of approach; Incremental Intervention originated by Roat (1996) defines the primary focus in health care interpreting as clarity of communication. To achieve such clarity, linguistic clarification, cultural brokering and limited advocacy might be needed.

The Incremental Intervention model (Roat, 1996) offers an array of roles, ranging from the least intrusive role of conduit, to clarifier and to the most intrusive role of advocate. It allows the interpreter a legitimate way to intervene if s/he perceives that a misunderstanding or misrepresentation is occurring (Avery, 2001). However, the interpreter is recommended to keep in mind the programmatic and institutional context as well as the wider cultural and political context. This is a complex approach to

interpreting, however, as in the health care setting procedure, culture, treatment and roles may not be straightforward for the clients. Therefore the proponents of this perspective are concerned with the neutrality that is likely to become disengaged Avery (2001).

The extended role of interpreters as a response

Interpreting in the health care settings has been steadily increasing due to the constant flow of people from war-torn countries to the developed ones. This development has been putting extra pressure on health care systems (Tribe, 2002). This has resulted in not only the poor quality of consultations but also in the duplication of ordered tests, misdiagnosis and inappropriate treatments and so forth. The adequacy of the staff has been under pressure: it is reported that few clinicians are adequately trained to treat the complex issues facing the refugees and immigrants in the USA (Dubus, 2009).

Since family members and bilingual health care workers are no longer viewed as beneficial but unethical and clinically unsound, professional interpreters in health care are increasingly in demand (Dysart-Gale, 2005). To carry out the complex set of tasks required for an effective interpreting, an interpreter or bilingual worker needs to have a broad range of skills and flexibility in the roles they undertake. Types of roles taken on by an interpreter can vary, depending on the need of the institution, the client and the mental health provider. Therefore, when challenged to meet the language and cultural needs of ethnic minority people, many social services turn to paraprofessionals who may not be clinically trained but are familiar with the language and culture of the communities being served. These paraprofessionals serve as interpreters, outreach workers and often co-counsellors (Dubus, 2009). Some authors used different titles to indicate additional and extended roles, for example Dubus (2009) and Tribe & Tunariu (2009) have used the terms of meta-professional or co-clinicians that imply an equal position in offering health care to clients/patients. Davidson (2000) added the term, co-diagnostician, noting that interpreters actively evaluate information for its value and interpret accordingly. The co-diagnostician role is also defined as adopting strategies that extend beyond interpreters' functions (in Hsieh, 2007).

Miklavcic and LeBlanc (2014) provide extensive information about culture brokers and their input into the clinical work. Cultural mediation, they argue, is vital when clinicians need to identify the macro- social dynamics of a patient's case. When needed, the culture

broker tries to obtain and provide information on the difficulties of the patient's life to help differentiate normative cultural and linguistic modes of expressing distress from psychiatric signs or symptoms. They may offer a tentative analysis of the significance of the cultural idioms or 'idioms of stress' to the service providers (ibid, p.126, 134). The authors conclude that the cultural mediation approach can extend outside the medical/therapeutic setting in that the culture broker acts as a liaison between different institutions and the patient and his or her family, in order to promote social and legal dimensions of the patient's well-being (p.121).

Although there are different usages towards the extended roles offered by several authors, Raval (2005, p. 9) has listed the extended roles of interpreters as following:

- Translator (provides direct language interpreting, but may include translation of concepts or metaphors or meaning);
- Advocate (represents the service user's or community interests);
- Cultural broker (enables one person to understand and negotiate the cultural context of another);
- Cultural consultant (provides a consultation to the practitioner about factors that may be relevant to understanding a service user's cultural context);
- Intermediary (takes on the role of resolving conflict between the practitioner & service user);
- Link worker (helps practitioners and service managers identify the health and social care needs of the local community);
- Community worker (helps build up the capacity for people to deal with mental health issues within the communities themselves);
- Co-facilitator (takes on a more active role with the practitioner).

An explanatory framework: Creative Tension¹⁵

We are approaching the ‘super-diversity’ status (Vertovec, 2006) in developed countries particularly and new research suggests that with the new and extended understanding and approaches amongst mental health providers, it will be possible to help the culturally different clientele for the better.

The ideas and attempts to accommodate a variety of modes of interpreting have led policy makers to be inclusive in their models. Also, the dedication and conscientiousness of interpreters, providers, members of diverse communities, trainers, policy-makers and of researchers to their work were acknowledged after long discussions in the National Council on Interpreting in Health Care (Avery, 2001). The goal of the ongoing dialogue is not to agree upon a single, ‘universal’ definition of the role, but to appreciate the different perspectives as interdependent aspects of a dynamic and continuous evolution of the field. This continuing evolution is grounded on an important principle of growth, development and the creative tension between the polar perspectives in the field.

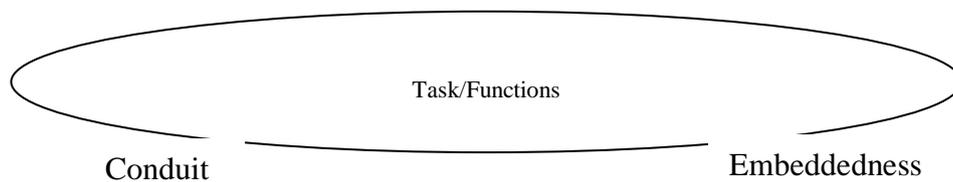


Figure 1: Creative Tension connecting the different perspectives

The term ‘creative tension’ is borrowed from Peter Senge by Maria-Paz Beltran Avery to describe the tension within organizations between the vision of where the organization wants to be and the current reality of where the organization is truthfully (Avery, 2001; p.14). On the graph, both polarities are critical. The conduit perspective keeps the field grounded in the central function of the interpreter. The embeddedness perspective challenges the profession to consider its place in a holistic view of the patient’s well-being. In the middle are the perspectives of the interpreter as manager of the communication process and of the incremental intervention model.

The evolution of the role will continue, and the dialogue will be energized by the creative tension between the polar perspectives. Without the conduit perspective, the profession

¹⁵ The permission for the use of the graph has been obtained from the author in September 2016.

runs the danger of losing its focus. Without the embeddedness perspective, it runs the danger of losing the heart and spirit of those for whom the survival of their communities is paramount (Avery, 2001).

Professional issues for interpreters and service providers

This section highlights what professionalism entails for interpreters. In this regard, the interpreters' needs and the expected skills and competences from them will be explained.

The need for interpreters and their professionalisation

It is reported that the mental health profession has recently turned its attention towards developing culturally sensitive therapeutic approaches both in the UK and the USA (Javier 1989; Sue, 1990; Sue, Fujino, Hu, Takeuchi & Zane, 1991; NCCC, 2004). This is due to the increasing numbers of people coming from other parts of the world and the increasing demand for diverse mental health services in working with culturally different clients (NCCC, 2004; IAPT, 2007; Refugee Council, 2006; Home Office, 2008).

In working with these culturally different clients, a shared language is crucial. It is a facilitating factor in establishing rapport between the client and the professional, and a vital means of transmitting values, practices and beliefs. It is even regarded as a significant source of national identity in many cultures (Atkinson, Morten & Sue, 1989). Not having a shared language can be a significant barrier in utilizing the services and, also, in making accurate assessment to identify those needs. Kelley and Patel (2006) studied the social care needs of refugees and asylum seekers in the UK, and reported that a quarter of the female respondents had no English language skills compared with 28% of the men.

Interpreting is performed in the conduit model in most medical settings. The fact that interpreting services were offered by mostly untrained ad hoc interpreters and family members in the past (Tribe with Sanders, 2003), has not been satisfactory for many clients when dealing with emotional and psychological problems. In one study, interpreters reported that patients found the direct and closed questioning style of physicians difficult, suggesting that a more narrative approach would serve both better information-gathering and therapeutic alliance (Hudelson, 2005).

Ongoing dissatisfaction with the work and the outcomes in clients, patients, interpreters, health care professionals and service providers has shown an increasing need for the professionalisation of the interpreting sector and interpreters. This has had an impact on the policy development of relevant institutions and policy makers, which resulted in the development of the code of ethics and guidelines. The code of ethics for interpreters aimed to give them the opportunity of being integrated into clinical work without influencing the patients, and conforming to the hospitals' standards, for Avery (2001), this would give them the sense of being a part of the whole team.

Organizations that worked for professionalization of the sector heavily emphasized the importance of neutrality, completeness and accuracy in the practice, idealizing the accurate, faithful and thorough interpretation without any distortion, addition or omission (Craig, 1999). However, this working model has not been adequate in other areas such as education and mental health. As Avery (2001) argues, in the settings, interpreters feel the need to empower the clients, even patients in health settings, improve their well being, and encourage their compliance with the treatments or policies.

It is also reported that these various guidelines have failed interpreters in deciding which role and when a certain role is appropriate to adopt (Kaufert & Putsch, 1997). Expansion of the roles of interpreters has led the debates amongst practising interpreters as well as policy makers (Avery, 2001). Critics argue that the expanded roles do not give them adequate guidance as to how to function in these roles (Costa, 2011; Miklavcic & LeBlanc, 2014). They became trapped between restrictive understanding of the conduit model and poorly-articulated boundaries of alternative roles (Haffner, 1999). But acknowledging the limitations of the model has created wider room for flexibility. Communication is no longer seen as only one way, and interpreters are required to act in more complex ways in health care settings (Working Group of the Minnesota Interpreter Standards Advisory Committee, WGMISAC, 1998).

The required skills for interpreters

To carry out the complex set of tasks, an interpreter or bilingual worker needs to have a broad range of skills and flexibility in the roles undertaken. Many over-stretched services tend to provide interpreting services through untrained staff or ad hoc interpreters in educational and healthcare settings (Putsch, 1985). Ad hoc interpreters or family

members are not acceptable in most settings particularly in health care due to lack of training, and the sensitivity of the health care encounter. In mental health training and experience in particular, it is not common for interpreters to have had previous experience (BPS, 2008).

Interpreters are expected to be competent in many aspects of communication. They ought to possess a good memory, active listening and message conversion skills and a clear speech delivery for an effective interpreting process. The National Council of Interpreting in Health Care (2009, p.4) has produced a list of the most important skills required for interpreters:

- A familiarity with regionalism and slang in both languages,
- A working knowledge in related fields,
- The ability to identify the differences in meaning for effectiveness,
- The ability to communicate in all registers and at varying levels of formality,
- A thorough understanding of colloquialisms and idiomatic expressions,
- An understanding of key concepts such as confidentiality and informed consent,
- A command of vocabulary related to the provision of health care in both languages,
- An accuracy in distinguishing the main ideas, a sensitivity to register and the ability to make eye contact,
- Skills in reading ahead, paraphrasing, and the use of synonyms,
- Skills in text organization and using problem solving strategies,
- A detachment from written words and pronunciation.¹⁶

¹⁶ <http://www.brad.ac.uk/staff/pkkornakov/META.htm>

Cultural competence and working with interpreters

This section explores cultural competence in relation to developing culturally sensitive services and working practices for mental health practitioners and interpreters. It will proceed to explore what cultural competence entails when it comes to developing and delivering much needed interventions. Finally, it summarizes what to look at when hiring or employing interpreters in service development.

Cultural competence

Cultural competence is regarded differently in some circles; for example, some see it as a set of skills that facilitate cultural mediation in the clinical practice, whereas others see it only as a means of using medical interpreters who can potentially act as practitioners (Miklavcic and LeBlanc, 2014)

Asylum seekers, refugees, community leaders and practitioners in the UK expressed their concerns about the over-medicalization of the asylum-seeker experience and recognised how this can create a tension for some health practitioners who are reluctant to respond medically, to what they see as a social problem (e.g. depression caused by isolation, lack of information and poverty) (Summer, 2005).

It is reported that mental health practices that lack cultural competence in fact prevent clients from a different culture receiving the care they deserve (Whealin & Ruzek, 2008). The USA originated Cultural Competence model of health care asserts that health care providers must be able to mediate cultural meanings with their patients. Widely used in European settings, the cultural mediation model sees the culture broker as an “expert on culture,” whose roles also include preventing conflicts, and acting as agents of social integration (Miklavcic & LeBlanc, 2014; p.118).

Acknowledging the mental health needs of asylum seekers and refugees, particularly those of men, for example, is important on an individual level and societal level. Summer (2005) reported that many men in consultations identified the asylum process as undermining their manhood, and that it was difficult to ask for help, especially regarding their emotional problems. Most of the men expressed concern that they were often excluded from the support mechanisms. He also reported that women do not disclose

domestic violence to the police due to fear that it may impact on their asylum claim and fear of the repercussions for their husbands (ibid, 2005).

Cultural competence includes a set of attitudes and policies ranging from behaviours, knowledge, skills and attitudes to the structures when working effectively across groups (Cross, Bazron, Dennis & Isaacs, 1989). Whealin and Ruzek (2008) argue that mental health practices and clinics should use an analytical process to evaluate their strategies when working with and through multiculturalism. To develop cultural competences, the authors listed ten interrelated achievable steps:

- Obtain organizational support
- Review and update mission and policies
- Improve the staff's knowledge about community populations
- Evaluate and enhance the staff's cross-cultural skills
- Build cultural diversity among staff
- Assess client needs and beliefs
- Adapt procedures, infrastructure, and physical environment
- Facilitate verbal and written communication
- Collaborate with spiritual leaders and traditional healers
- Evaluate findings, identify goals, and disseminate recommendations.

Positive practice in working with interpreters

Using interpreters in the health services is inevitable and can significantly change the dynamics of any therapeutic encounter in the mental health field particularly. It also increases the level of engagement of clients and their understanding of their situation, and establishes trust in the process and rapport with the healthcare provider (Manson, 1988). Using interpreters also results in fewer emergency visits, improved client satisfaction and better compliance with treatments (Eyton, Bischoff, Rrustemi, Drieux, Loutan & Gilbert, 2002).

Good preparation and planning are considered good practice before starting any interpreting session. Tribe and Lane (2009) suggest professionals spend some time thinking about the implications of working within a triadic framework. Since communicating through a third person can create transference and power issues, discussing them with an experienced member of staff may prove very useful. The authors suggest that service providers who work with interpreters consider the following (p. 239):

- Being aware of the cultural nuances in translating certain words and concepts.
- Reflecting upon these points before and after the session and considering booking a longer session, bearing in mind that longer sessions can make interpreters tired.
- Being aware that interpreters will not be asked to carry out any additional tasks by either staff or clients.
- Making sure that the setting will be comfortable to enable interpreters to work most satisfactorily.
- Being sensitive to issues like gender, faith, sexuality when working on rape, torture and domestic violence cases. In these cases, it would be advisable to use the same interpreter.
- Ensuring that service providers would be working with interpreters who had experience and understanding in mental health.
- Professionals should assure interpreters that they can ask for clarification in case of confusion, and that service-providers should not use colloquial language, proverbs or technical terminology (Tribe & Lane, 2009). Some organizations ensure a specialized psychology or medical dictionary is available (Tribe & Morrissey, 2004).
- Conversations should be made at a slow pace without making speech segments too short so that conversation does not lose its rhythm. During the sessions, service providers must not discuss any issue unrelated to the client such as availability for further appointment or other management-related issues (NCIHC, 2009).

In terms of good practice, many authors have recommended that interpreters should be offered after-session conversation to reflect and explore what the interpreters think about the sessions. The most common recommendations and observations are:

- that interpreters will be paid for the extra time that spent in reflecting and briefing (Tribe & Lane, 2009).
- that longer and sensitive sessions can be tiring and draining for interpreters as well as clients (Razban, 2003).
- that clients sometimes feel uncomfortable about the interpreters' presence and the possibility that information about them might reach the community where the client lives (Tribe and Raval, 2003).
- that interpreters should be told that they do not have any decision-making powers (Tribe and Sanders, 2003).
- that interpreters adhere to the written guidelines and code of practice to ensure their awareness of confidentiality, trust and anonymity (Tribe & Lane, 2009).
- that the room should be organized appropriately: a layout such as the positioning of chairs in a triangle should allow each to see the other. However, some professionals may prefer interpreters to sit behind the client (Cushing, 2003).
- that care should be taken when booking interpreters to carry out psychometric tests as these tests are validated for the hosting population. It may mean that the results will be severely compromised (Holt, 2005).

It is therefore important to know which elements to look for in hiring or employing interpreters. Being bilingual or having a certificate may not be adequate to achieve the best practice. Standards of practice are important aspects of interpreters and they are a measure of 'best practice' in delivering the services.

Tribe & Lane (2009) recommend that interpreting agencies and service providers carry out a formal assessment before establishing their services. This is believed to effectively match with the language needs of ethnically different people in the communities. To do so language services and service providers must ensure that interpreters are offered

appropriate induction and training in mental health, support and supervision, informed about the policies and codes of conduct of the relevant settings and take care when dealing with sensitive issues and feeling overwhelmed (ibid, p. 237).

This chapter explored a wide range of topics that are pertinent to counselling and psychotherapy, the impact of language and culture, working with non-English speaking clients and interpreters, and the competencies in these fields.

This study seeks to generate knowledge and further insights into the dynamic processes in triadic therapeutic relationships. Some studies fail to give voice to non-English speaking clients; some worked on anecdotal accounts retrospectively, and some focused only on certain experiences. This research, in this regard, aims to fill the gap in the literature in relation to airing the clients' points of view which were not necessarily well understood. It also aims to provide the complementary aspects of the phenomena from all angles of the triad members.

The next chapter will provide the details regarding the methodological aspects of the study including the researcher's reflexive statements.

CHAPTER 3: METHODOLOGY

Introduction

This chapter includes an outline of the study, research aims and questions, a rationale for the methodology, research design, data collection and analysis, the recruitment and selection processes of the participants, ethical considerations, reflexivity, the researcher's philosophical stance, and validity and reliability checks.

Research aims and questions

This qualitative research aimed to achieve the following:

- to explore the dynamics of the three-way relationship between clients, counsellors and interpreters.
- to understand how the members of the triad make sense of the triadic therapeutic relationship.
- to provide an overview of all the participants' representations of their experiences.

In doing so, a triangular study was designed and each member of the triad was approached for their own experiences. First, a group of interpreters; secondly, a group of counsellors and thirdly, a group of clients were interviewed to explore their experiences in relation to interpreting for non-English speaking clients, to working with interpreters and to receiving emotional help through interpreters. Although the questions varied slightly for each group, the main research questions were:

- to what extent do non-English speaking clients feel helped in counselling when an interpreter is present?
- how do interpreters cope with the emotional demands of working with counsellors and non-English speaking clients?
- in what ways are counsellors helped or hindered in developing a relationship with a client in the presence of an interpreter?

- how does each member of the counsellor, client, interpreter triad cope when difficulties are encountered?

Outline of the study

This study was carried out in three stages:

In Stage 1, the perceptions of a group of interpreters and counsellors about language, culture and communication, the interpreting work and working in a triadic framework with non-English speaking clients were explored in group settings, using the focus group method.

In Stage 2, taking it on further from the first stage, the issues and concerns raised in the focus groups were further explored through in-depth interviews. Another group of interpreters and of counsellors were interviewed face-to-face to obtain rich and diverse data relating to the participants' perceptions of working with non-English speaking clients.

In Stage 3, the clients' points of view were explored in relation to their experiences of receiving emotional help from two strangers: the counsellor and the interpreter. The clients' experiences were obtained through semi-structured in-depth interviews only.

Rationale for the method

A qualitative inquiry was considered the most appropriate choice for the research as it offers a flexible yet structured approach in obtaining rich data about peoples' perspectives about any phenomena that are little known (Denzin and Lincoln, 1998; Corbin and Strauss, 1996). It has been widely used in research in social sciences, education and health care.

The researcher attempted to explore the shared experiences of interpreters, counsellors and clients in relation to working through and being helped by a third person. The researcher was concerned with the meaning derived from the participants in relation to their experiences of working through language and culture, how they perceived other members of the triad, and their perceptions of the working arrangements and the settings where the consultations took place.

Qualitative research inquiry has its own epistemological stance. Flick (1998) considers methodology as the status of the text, and this status is largely informed by the researcher's epistemological position. McLeod (2001) highlights that this stance is philosophically characterised by relativism, an image of the person as a reflexive agent. McLeod (2000; p.56) notes the mutually involved nature of language, culture and qualitative research:

‘We can never be free of the ‘pre-understandings’ or ‘prejudices’ arising from belonging to a culture and from using a certain language... Therefore, qualitative researchers are bound to work within an interpretative approach... putting inquired subject into historical and cultural perspective.’

Although the philosophical underpinnings of the qualitative research will not be detailed here (Please see ‘Researcher’s Philosophical Assumptions’ section), it can be stated that qualitative research is concerned with the exploration of thought processes, choices and actions, and that qualitative methods allow researchers to understand participants’ opinions and preferences, and then develop patterns of relationships between the categories and themes within and across the data sets. A qualitative research method was therefore selected as an effective way of informing related fields and contributing to what is already known with regard to the dynamics of triadic therapeutic relationships.

Willig (2001) adds that qualitative research methods allow the study of a given research topic within the contexts that the phenomena were observed, such as communities, schools and clinics which she calls ‘open systems’ where action takes place. In this research, participants were interviewed in their work places and asked to reflect on their perception of the premises they were working.

The final rationale was the emphasis that qualitative research made on the researcher’s involvement as an active agent and part of the process (Miles & Huberman, 1994). The researcher aimed to give voice to the participants, to interpret and represent their assumptions and interpretations in a coherent way that could be analysed by the researcher.

The research design was exploratory, interpretative as well as descriptive and contextual. Thematic analysis was used to identify explicit and implicit patterns of meanings and themes within and across the data sets.

The researcher's philosophical stance

The researcher was particularly concerned with the meaning and quality of their experiences, searching for patterned meanings. In this regard, the study is ontologically and epistemologically based on post-modernist, social constructionist and interpretivist views in approaching and analysing the data.

The perception of reality can be personal and emotional as well as objective. As opposed to the positivist view, postmodernism challenges the modernist notion of reality and universal knowledge that can only be observed as a single measurable and identifiable object (Lyotard, 1979; Sarup, 1993; Gelo, 2012; Guba and Lincoln, 1994). The post-modernist approach asserts that reality can be observed from and within the eyes of the observer (Dickson-Swift, James & Liamputtong, 2008). The researcher holds the ontological assumption that reality can be conditional, depending on who perceives it, when and how it is experienced, and therefore, as Guba and Lincoln (1994) suggest, there can be multiple and local realities for different people owing to how they are psychologically and socially situated in their lives.

Social Constructionism asserts that people experience their lives through the lenses of history, societal structures, languages and cultures (Gergen & Gergen, 1991). Social constructionism has become a significant postmodern influence in counselling literature (e.g. Cottone, 2001; Guterman, 1996; Rudes & Guterman, 2007) and underpins this work.

Language particularly is an important agent of a socially constructed world (Potter and Wetherell, 1987). So, there are 'knowledges' rather than 'knowledge', Willig (2001) asserts, adding that it does not mean that we cannot understand the human experience. We can critically explore and read the impact of both internal and external factors; people choose to see the world by looking at a half-filled glass of water as 'half-full' or as 'half-empty' depending on their personality type (p.7).

However, the social constructivist approach is unable to effectively assess the impact of power-related issues within the socially constructed realities (Whitmore, 2001). Here,

the critical-ideological position questions power imbalance, and seeks to empower participants with a view to challenging and changing those inequalities. The Critical-Ideological view asserts that there is a historical realism that has shaped political, historical, economic, cultural and gender values (McLeod, 2001). The Feminist social constructionist Haraway (1988; p.581) further argues that regardless of how things are perceived by people or of how the knowledge is situated, there are some realities, for example, lived experiences.

A feminist discourse requires caution in accessing reality and people's perceptions. Reality is perceived by people in response to their needs. There are differing realities in society, for example, for people with disability etc. who experience, tangible and observable hardship. These cannot be put down to their perceptions only but to societal, political and economic structures they experience. There are extreme views in these two spectrums: for example, some argue that there is no absolute truth for everybody, everything is one way or another perceived in certain ways and therefore people do not have access to reality (Polkinghorne, 1983). Some authors warn against extreme relativism of a 'view from nowhere' as opposed to the positivist view of a 'view from above' (Haraway, 1988; McLeod, 2001). Qualitative research aims to tackle this issue by providing the voice of the respondents.

Throughout the study, the researcher regarded the participants' experiences and accounts as their realities and therefore aimed to reflect their thoughts, their feelings and what occurred in their environments. The themes and accounts that emerged were real snapshots of their experiences.

Reflexivity of the researcher

Reflexivity is one of the most important pillars of qualitative research. It acknowledges that the research and the researcher are intertwined and thus become the product of the context in which the researcher lives and the research is carried out. Haggerty (2003; p.158) defines reflexivity as

‘...a performance that positions the author in relationship to the field, the act of research, writing and the production of knowledge more generally.’

Woolgar (1988) sees reflexivity on a continuum: radical reflexivity whereby knowledge creation is interdependent. That is, knowledge of an object becomes an act of representation filtered through an author's or researcher's preconception, experiences and bias. Introspective reflection is a kind of reflexivity that entails loose injunctions to 'think about what we are doing' (p.22). The practitioners then develop a repertoire of practices and frames of reference that help in making informed decisions.

Reflexivity involves reflecting upon our own values, experiences, interpretations, beliefs and aims, acknowledging their impact on the research. It implies a capacity for bending back or turning back one's awareness on oneself (Lawson, 1985); Reflexivity becomes a reflection on the self in addition to facilitating people's personal lives becoming available and perhaps becoming public through reporting and writing up (McLeod, 2001). There is also a difference between reflexivity in counselling practice and reflexivity in counselling research (Etherington, 2004; McLeod, 2001). In counselling practice, for example, Rennie (2007) suggests that "clients are reflexive when becoming aware of their felt sense either prior to or at the outset of a meeting with their therapist. They are radically reflexive when thinking and feeling about this felt sense" (p.54).

The impact of the researcher is inevitable, and the experience and identity of the researcher always influence the 'findings'. McLeod (2001) argues that denial of it may lead to a 'distanced language' in which people and their concerns, feelings and significant events are not closely attended to. He argues that critical reflexivity lies between the approaches of looking into how the researcher was influenced by their contexts in relation to the research and the impact of the wider socio-political context on the research. As such, critical language awareness is regarded as part of reflexivity as language shapes our inner, and hence outer, worlds (Fairclough, 1995; Willig, 2001).

Stiles's (1993) guidance for reflexivity in relation to psychotherapy research includes openness and disclosing one's orientation; explaining social and cultural context and the description of internal processes of investigation (p.602). McLeod (1994) had identified six emerging trends with regard to reflexivity: greater awareness of the relationship between research and practice; permission to be reflexive; openness to new methods of inquiry; discovery orientation rather than verification; enhanced appreciation of power imbalances between researcher and participant; and displacement of an excessively

psychological concept of the person. In summary, reflexivity seeks to promote three key principles:

- awareness of the moral dimension of research,
- consideration of the process through which text is co-constructed,
- underlining of the necessity for new approaches to writing and communicating research findings (McLeod, 2013; p.196).

Following these elements, the researcher aimed to provide her autobiographical accounts and reflexive observations as part of the analysis, to further explore both explicit and latent meaning patterns within and across the data sets, and to reveal and attend the power imbalance that may inherently occur within the triadic relationships, the interpreting processes and also in the process of researching. The researcher tried to underline the impacting factors for all parts throughout the processes and link them with the participants' emotional, social and psychological well-being.

The researcher also attempted to exercise 'Perspectivism' which seeks to work 'with the multiple perspectives that correspond to the multiplicity of coexisting, and sometimes directly competing, points of view' (Bourdieu et al. 1999; p.3). It may seem that 'multiple stories' for a single phenomenon are not convincing for some or as McLeod (2003; p.209) argues '...might appear to be a kind of lazy postmodernism', but in fact are placing multiple factors onto the subject matter. This research does not aim to explore and interpret individual interviews on their own, but to achieve a cumulative outcome without losing the individual inputs. The points to be made by the participants will be used to explain the current and wider socio-psychological-economic and political concerns within society by analysing and placing the perspectives of the three 'actors' for the same triadic therapeutic relationship and the interpreting process.

Not only has the researcher reflected on the qualitative method but she has also utilised reflection on the transcription. Understanding and monitoring the transcription process are key aspects of qualitative inquiries (Please see 'Transcription Process' section).

Researcher's reflexive statement

My reflection relates to my privileged position of being both a mental health professional and practising interpreter. I feel that I hold the advantage of having insight into and experience of various mental health settings. However, claiming that I did not have any bias would be unprofessional and unfair to the participants and the research process. Although I have been aware of it from the very beginning, most of the time I still felt protective towards my participants and their shared accounts; this may suggest that I was too close to them. This tendency was monitored and an attempt made to prevent it by strict adherence to the ethical standards, the professional codes of conduct and, also by the researcher's ongoing reflection that was regularly shared during the supervision sessions throughout the study.

Further reflexive statements made by the researcher are given at the end of this chapter.

Research design and data collection

The research design consists of piloting, focus groups and semi-structured in-depth interviews. Data were collected from three groups of participants: Interpreters, Counsellors and Clients. In the following sections, the participants will be given in the order of recruitment, that is, first, the interpreters, then counsellors and lastly the clients. All data sets were collected through two sets of focus groups and three sets of individual in-depth interviews.

Piloting

An interview was carried out with a Turkish interpreter in English. The aims were to increase the familiarity of the researcher with the process in terms of planning the session, recording and collecting socio-demographic information, and to test out the timing, the equipment and the questions. The trial was satisfactory, and the feedback provided by the interpreter in relation to unclear questions, the order and the wording of the questions and timing were reflected in the new interview guide. This recording was not included in the analyses as the participant instructed to do so.

Focus groups

The focus group method is one of the most widely used qualitative research methods. It is considered the most appropriate model for this stage of the study owing to its advantage of obtaining participant responses in interaction. It can be considered a group interview and is preferable to individual interviewing as some people might find in-depth interviewing intimidating (Morgan, 1997).

Focus groups are advantageous for the researchers as well as for the participants in terms of becoming involved with the topic in a group environment, of being able to talk, listen, observe and record spoken utterances, attitudes and behaviours at the same time (Field, 2000).

A typical focus group usually consists of five to twelve people, and lasts 1-2 hours (Field, 2000). Researchers seek to provide an environment that nurtures the different perceptions and points of view to be shared (Krueger, 2002). Therefore, it is important to ensure that all participants take part in conversation as much as possible, and that group members have some of knowledge of the issues discussed (Stewart and Shamdasani, 1990).

Kruger (2002) listed different types of questions to use in focus groups such as ‘Opening questions, Introductory questions, Key questions and Ending questions’ with time limits for each. Kruger also provided a checklist for group moderators to use, and these include checking all the technical equipment, offering refreshments, arranging the room accordingly, taking notes and summarising or debriefing at the end.

In this study, two focus groups were organized with a group of interpreters and a group of counsellors. The researcher aimed to engage with the participants from the beginning, and be informed by the interpreters and counsellors particularly towards the development of the questions to be used in the semi-structured in-depth interviews. This method was preferred rather than deriving the interview questions from the literature.

Setting and procedure

Both focus groups were organised through a community counselling organisation that was offering talking therapies and capacity building courses to clients from all sections

of society including asylum seekers and refugees. Health and safety checks were ensured by the organisation.

The group talk lasted one and a half hours. It was facilitated and moderated by the researcher. The room assigned for the sessions was suitable for the research purposes in terms of its neutral colour and layout, and of its being quiet. The participants were greeted at the door on the day of the meeting and offered refreshments. They were then briefed about the research and the procedure. Before starting off the group talk, their consent was obtained by the researcher. Recordings were made, using both a laptop and a tape recorder.

Participants

Two separate sessions were carried out with a group of five interpreters and a group of five counsellors. In this section, the participants' demographic characteristics and information on how they were recruited and selected are given in the order of the recruitment. Table 1 shows the interpreters' socio-demographic characteristics.

Interpreters' socio-demographic characteristics

Socio-demographic variables	Pseudonyms of the participants ¹⁷				
	Ali	Ameer	Julie	Layla	Parveen
Gender	<i>Male</i>	<i>Female</i>	<i>Female</i>	<i>Female</i>	<i>Female</i>
Age	<i>34</i>	<i>48</i>	<i>24</i>	<i>56</i>	<i>47</i>
Marital status	<i>Married</i>	<i>Single</i>	<i>Single</i>	<i>-</i>	<i>Divorced</i>
Education	<i>Islamic counselling</i>	<i>Midwifery</i>	<i>MSc Psycho</i>	<i>NVQ 1-3</i>	<i>IPSI (Interpreting)</i>
Main occupation	<i>Teacher, Support worker</i>	<i>Translator</i>	<i>Managing Director</i>	<i>Interpreter</i>	<i>-</i>
Ethnic background	<i>Pakistani</i>	<i>Azerbaijani</i>	<i>Bosnian</i>	<i>Iran</i>	<i>Indian</i>
How many languages spoken	<i>7</i>	<i>3</i>	<i>2</i>	<i>3</i>	<i>4</i>
Duration of stay in the UK	<i>8 years</i>	<i>10 years</i>	<i>14 years</i>	<i>40 years</i>	<i>10 years</i>
Duration of work in interpreting	<i>3 years</i>	<i>7 years</i>	<i>14 years</i>	<i>6 years</i>	<i>10 years</i>

¹⁷ The names used in the tables are the names that the participants wanted to be called throughout the study.

Any training received	<i>None</i>	<i>Short trainings</i>	<i>None formal</i>	<i>Certificate</i>	<i>Short trainings</i>
Setting worked	<i>Health/ Social</i>	<i>Health</i>	<i>Health</i>	<i>Health</i>	<i>Legal & Health</i>

Table 1: Socio-demographic information of the focus group interpreters

Interpreters' recruitment and selection

Interpreters were invited through Interpreting and Translation agencies operating across the UK. These agencies were initially sent the prepared information about the study, and the managers were asked to circulate this information to their registered interpreters. The information pack included the researcher's letter to the agencies with the details of the study, the procedure of carrying out focus groups, the consent form and information about ethical considerations. The interpreters were further ensured of the confidentiality and anonymity and their right to withdraw.

The interpreters were selected on the basis of having experience in mental health interpreting, having worked with mental health professionals and being registered with an interpreting agency. After an agency provided details of the interpreters who expressed their interest in taking part, the researcher contacted and sent all the information to these interpreters. In some cases, the interpreters directly contacted the researcher and received the information in the post.

Although ten interpreters in total expressed their interest in taking part, five attended. Two Chinese interpreters contributed by answering the questions on paper and posting it to the researcher. But it was later decided not to include these in the analysis as they were not collected through interactive interviewing, and the researcher aimed to give equal opportunities to all participants. These participants were informed of this decision.

Counsellors' socio-demographic characteristics of the focus group

Below is the socio-demographic characteristics of counsellors.

Socio-demographic variables	Pseudonyms of the participants				
	Yan	Ali	Yigido	Flora	Ruby ¹⁸
Gender	<i>Male</i>	<i>Male</i>	<i>Male</i>	<i>Female</i>	<i>Female</i>
Age	<i>53</i>	<i>41</i>	<i>45</i>	<i>48</i>	<i>25</i>
Education	<i>BSc. Psycho MSc. Counselling Psychology</i>	<i>Foundation degree in Counselling</i>	<i>Mechanic</i>	<i>Diploma in Counselling</i>	<i>BSc. Psychology. MSc Forensic Psychology</i>
Current occupation	<i>Director /Counsellor</i>	<i>Well-being practitioner</i>	<i>Support worker</i>	<i>Counsellor</i>	<i>Managing Director</i>
Duration of work (years)	<i>20</i>	<i>2</i>	<i>4</i>	<i>4</i>	<i>4</i>
Ethnic background	<i>Jewish/ British</i>	<i>Bangladeshi</i>	<i>Black African/ Eritrean</i>	<i>Caribbean</i>	<i>Bosnian</i>
Bilingual or Bicultural	<i>Bicultural</i>	<i>Yes to both</i>	<i>Yes to both</i>	<i>No</i>	<i>Yes to both</i>
Training: Working with ethnically diverse clients	<i>Variety of courses</i>	<i>Trainings in Level 2 and 3</i>	<i>Counselling, horticultural therapy</i>	<i>Yes</i>	<i>Yes, through the organisaiton</i>
Supervision received	<i>Yes. Monthly. External</i>	<i>Yes.</i>	<i>Yes</i>	<i>Yes</i>	<i>No</i>

Table 2: Socio-demographic information of the focus group counsellors

Counsellors' recruitment and selection

The counsellors were recruited through one of the community counselling organisations in Birmingham. It was based in an ethnically diverse area and offering talking therapies and capacity building courses to both NHS and self-referrals. Some of the counsellors had had the experience of working for this organisation.

The participants were selected on the basis of having at least three years of work experience in the field, experience of working with ethnically diverse clients whose first

¹⁸ This participant took part in the study both as an interpreter and a counsellor in both focus groups.

languages were other than English, and experience of working with interpreters, particularly in mental health settings. They were informed about the procedure for the data collection and the methods to be used, the topics of the group talk, and about ethical issues such as anonymity of their names in the event of publication.

Seven participants attended. But, two participants could not stay long enough to complete the sessions. Therefore, their inputs were not included in the analysis.

Researcher's reflexive observations on the focus groups

The group talks with both the interpreters and the counsellors had successful outcomes. When I reflect back on them, I have realized that I was too excited about exploring the issues with the participants. It was a mutual excitement that made the participants eager to come forward and share their views. I was, however, aware of not wanting to impose any agenda nor letting my curiosity go beyond the topic.

I seemed to be probing some participants more in the interpreters' group than the counsellors' group as they presented themselves as timid or unsure. Encouraging them in the beginning energized the group's motivation. I also realised that I challenged some participants in a kindly Socratic way, asking them to clarify or elaborate their points further. This helped them to be precise and sensitive yet contradictive in relaying their thoughts.

Moreover, my realization of the researcher's impact on the process came to life when I started transcribing the data. The text itself felt emotional and lively. It was diverse, rich and complex in content. But towards the end, I found the process exhausting in aiming to transcribe verbatim and to capture not only the essence of their opinions but also the feelings of the participants. Overall, this has enhanced the quality of the research. Moreover, most participants, off the record, stated that they had felt good and relieved at being given an opportunity of airing their thoughts with someone who was closely involved in the topics.

As a researcher, it was good practice for me to observe that group talk can be highly productive if the topics are chosen appropriately and the ethical guidelines and boundaries are adhered to.

Learning from the first experience, I was a little more hesitant in probing the participants in the counsellors' focus group. Unlike the interpreters' group, I knew most of the counsellors due to us having worked in the same organisation in the past. This quickly established a feeling of trust between us. The counsellors were highly articulate and fruitful in their arguments; they too were excited and keen on contributing as they stated that the research was on the subject that they were trying to improve. I therefore did not interfere as much as I did in the first group.

In-depth interviews

This research aimed to gain insights into three different groups of participants' understandings and perceptions of triadic therapeutic relationship, of the process of offering emotional help and being helped through a facilitated communication. After identifying common issues and difficulties in the fields through two separate focus groups, the researcher further aimed to explore the issues through semi-structured interviews with different interpreters, counsellors and a group of clients.

Semi-structured interviewing is compatible with many qualitative approaches and emphasizes the meaning of what was said (Willig, 2001). It is a powerful tool in studying perceptions, feelings, attitudes, connections and relationships of people, and is especially appropriate for addressing sensitive topics that people might be reluctant to discuss in a group setting. It is however more than a simple chat, and was described by Bingham and Moore (1959) as 'conversation with a purpose' (in Banister, Burman, Parker, Taylor and Tindall, 1994; p.49).

Individual interviewing offers flexibility to the researcher in that researchers can tailor their questions according to interviewees' positions (Burman, 1994) and formulate new questions as topics arise (Etherington and Nell, 2011). This feature was particularly pertinent to the current study as the researcher aimed to be informed by the respondents' views and emotional responses.

Individual interviewing is advantageous for the participants: they are given privacy and a conducive, convenient platform to express themselves. Since it is a highly dynamic process, potential power dynamics should be monitored because of the nature of the relationship between the researcher and the respondent. Banister et al. (1994) suggest researchers approach interviews with the attitude of 'research with' rather than 'research

on' (p.49). This stance was closely observed by the researcher who aimed not to puzzle or mislead any participants, and was ensured by observing the ethical and professional boundaries throughout.

Settings and procedure

The premises in which the interviews took place varied depending on the preferences and practical needs of the participants. The same counselling organisation where the focus groups were held was primarily utilized for the interpreters group. For the counsellors, two other counselling organisations were utilized owing to their preferences. Client interviews mainly took place in this community organisation, some in a library and few in other preferred places. Some counsellor interviews took place in the counsellors' work places, and others in a local school, an NHS setting and a private clinic. The health and safety of these premises were checked with the managers, and a risk assessment was carried out by the researcher, which is explained in the ethics application process.

The semi-structured interviews were conducted face-to-face with the researcher. The procedure was the same for all groups. The counselling organisations and interpreting agencies were initially written to about the research, its aims and the processes involved. The organisations and agencies either provided the researcher with potential names to approach or some participants took the initiative and contacted the researcher. After the initial agreement concerning the attendance, the researcher sent the information pack to the individuals who had expressed interest in taking part.

The participants were met by the researcher on the day of the interview at the door, the assigned room for the interview was shown, tea and coffee were offered, and house-keeping information was provided in line with the organisational instructions. The researcher set up the recording devices, and gave brief information regarding the process and other issues. The participants were asked to sign the consent form and fill in the biographical information questionnaire before the interviews started.

No names were taken. All participants were asked to come up with their chosen names to be called throughout the research. Interviews were completed without any problems apart from minor recording inconsistencies. Most of the interviews lasted around 45-60 minutes. At the end of the interviews, the participants were thanked, briefed and escorted to the door before they left. No further concerns were observed and recorded.

Participants

In total, twenty-nine participants were individually interviewed. Nine of them were the non-English speaking clients who received talking therapies with the aid of an interpreter. Ten were the interpreters and ten the counsellors, of whom only nine were new recruits as one interpreter and one counsellor took part both in the focus group and the interview. In addition, the data from five interpreters and five counsellors who participated in the focus group were included in the analysis.

The researcher, with the consultation of the supervisors, decided to include the data from the focus groups, merging the both data. The focus group conversations were therefore treated and analysed as interviews. The rationale for this was to keep and maximise the use of the data collected from the focus groups as they were highly rich in content, encompassing and diverse. This was not related to any recruitment difficulty but was about being truthful to and valuing the responses of the participants. Leaving the focus group data aside and using it only for the development of interview questions would have led to the omission of a large part of the data, as indicated by Willig (2001), jeopardizing the aim of giving voice to all participants.

All participants were recruited across the Midlands and England. Purposive homogenous sampling was used for the recruitment to obtain common perspectives (Smith, Flowers and Larkin, 2009). The researcher ensured that the data obtained was to be as representative as possible in terms of the work force and the ethnic background of the participants (Please refer to the 'Findings Section' for the Clients Socio-demographic characteristics.)

Interpreters' socio-demographic information

Table 3 shows the socio-demographic characteristics of the interpreters in the interview group.

Socio-demographic variables	Pseudonyms of the participants				
	Ann	Diane	Gigi	Jim	Meryem
Gender	<i>Female</i>	<i>Female</i>	<i>Female</i>	<i>Male</i>	<i>Female</i>
Age	<i>59</i>	<i>41</i>	<i>35</i>	<i>41</i>	<i>22</i>
Education/Qualification	<i>A levels</i>	<i>MA in Translation & DBSI Law</i>	<i>Diploma in I.T.</i>	<i>BA Psychol & PGR Diploma</i>	<i>BA Accounting & Finance</i>
Main occupation	<i>Interpreter</i>	<i>Interpreter & Translator</i>	<i>Tutor & Translator</i>	<i>Interpreter</i>	<i>Interpreter</i>
Duration of stay in the UK	<i>44</i>	<i>15</i>	<i>12</i>	<i>13</i>	<i>11</i>
Length of working in interpreting	<i>3</i>	<i>6</i>	<i>2</i>	<i>8</i>	<i>2</i>
Ethnic background	<i>Hindu</i>	<i>Italian</i>	<i>Albanian</i>	<i>Iranian</i>	<i>Somali</i>
How many languages spoken	<i>4</i>	<i>3</i>	<i>3</i>	<i>3</i>	<i>2</i>
Training towards working with counsellors	<i>Short and informal</i>	<i>Yes.</i>	<i>Yes.</i>	<i>Yes.</i>	<i>No.</i>
Supervision received	<i>No</i>	<i>No</i>	<i>Once a month</i>	<i>Monthly</i>	<i>Various</i>

Table 3: Socio-demographic information of the interpreters in the interview group

Recruitment and selection

The interpreters were interviewed after their expression of interest in taking part. They were similarly recruited through the interpreting and translation agencies operating nationally and regionally in the UK. All interpreters were interviewed at the community counselling centre in Birmingham.

The criteria for the selection of the interpreters were that they were registered with an interpreting agency at the time of the interviews; had a minimum 2-3 years of experience

in interpreting and particularly in mental health, and had experience of working with mental health professionals.

Counsellors' socio-demographic characteristics in the interview group

Table 4 shows socio-demographic information of the counsellor in the interview group.

Socio-demographic variables	Pseudonyms of the participants				
	Jane ¹⁹ (Flora)	Maria	Rosie	Sonia	Zishan ¹⁶ (Ali) ²⁰
Gender	<i>Female</i>	<i>Female</i>	<i>Female</i>	<i>Female</i>	<i>Male</i>
Age	<i>45</i>	<i>53</i>	<i>42</i>	<i>54</i>	<i>41</i>
Education	<i>Diploma</i>	<i>BA & Postgrad. diploma (Psych)</i>	<i>Diploma. Integrative Counselling</i>	<i>Degree. Psychotherapy</i>	<i>Diploma. Counselling</i>
Current occupation	<i>Counsellor</i>	<i>Clinical director & CEO of a counselling org.</i>	<i>Counsellor</i>	<i>Clinical director</i>	<i>PWP. Intensity worker. NHS</i>
Length of stay in the UK (years)	<i>45</i>	<i>53</i>	<i>42</i>	<i>54</i>	<i>35</i>
Ethnic background	<i>Afro-Caribbean</i>	<i>White European/Jewish</i>	<i>Pakistani</i>	<i>African/Caribbean</i>	<i>Bangladeshi</i>
Length of doing the current	<i>10</i>	<i>11</i>	<i>3</i>	<i>6</i>	<i>2</i>
Languages spoken other than English	<i>No</i>	<i>Spanish</i>	<i>Urdu/Punjabi</i>	<i>Caribbean Patais</i>	<i>Bangladeshi, Urdu, Hindi</i>
Training on working with interpreters	<i>Yes</i>	<i>Yes.</i>	<i>Yes</i>	<i>Yes</i>	<i>No</i>
Supervision received	<i>Monthly</i>	<i>Monthly</i>	<i>Monthly</i>	<i>NA</i>	<i>Forth-nightly</i>

Table 4: Socio-demographic information of the counsellors in the interview group.

Recruitment and selection

Counsellors in this group were recruited through the networks of the researcher and the community counselling organisation that was used previously. The specific roles of the

¹⁹ This counsellor took part both in the focus group and the interview.

²⁰ The bracketed names show the names used by the participants in the focus group.

most participants varied, such as therapist, counsellor or psychologist and all stated that they were offering counselling at the time of the interview. They will be addressed as 'counsellors' throughout with the aim of maintaining a consistency in the wording.

Two senior counsellors/therapists who resided outside Birmingham were interviewed at their premises where they were offering counselling and therapy. The rest were interviewed in the counselling organisation and a local school. It is important to note that the data from the focus group was merged as explained in previous section; so, out of ten counsellors, the data of five counsellors came from the focus groups, a further four different counsellors were recruited, and one counsellor took part in both the focus group and the interview.

The selection criteria for the counsellors were: to have a qualification in mental health; to have a minimum of 2-3 years of work experience; and to have experience of working with interpreters and non-English speaking clients.

Clients' socio-demographic characteristics

Table 5 shows the socio-demographic characteristics of the clients

Socio-Demog. Variables	Pseudonyms of the client participants								
	Kiraz	Ayisigi	Ozay	Martin	Slimlady	Perihan	Safiye	Roky	Baz
Gender	<i>Female</i>	<i>Female</i>	<i>Female</i>	<i>Male</i>	<i>Female</i>	<i>Female</i>	<i>Female</i>	<i>Male</i>	<i>Male</i>
Age	<i>47</i>	<i>31</i>	<i>50</i>	<i>38</i>	<i>38</i>	<i>41</i>	<i>-</i>	<i>65</i>	<i>55</i>
Occupation	<i>Housewife</i>	<i>Housewife</i>	<i>Housewife</i>	<i>Worker /FT</i>	<i>Housewife</i>	<i>Housewife</i>	<i>Worker / PT</i>	<i>Electrician</i>	<i>Electrician</i>
Education	<i>Primary</i>	<i>Secondary</i>	<i>Primary</i>	<i>College</i>	<i>University</i>	<i>Primary</i>	<i>High School</i>	<i>College</i>	<i>College</i>
Ethnicity	<i>Kurdish</i>	<i>Turkish</i>	<i>Turkish</i>	<i>Turkish</i>	<i>Turkish</i>	<i>Kurdish</i>	<i>Turkish</i>	<i>Bosnian</i>	<i>Bosnian</i>
Language(s) spoken	<i>Kurdish & Turkish</i>	<i>Turkish</i>	<i>Turkish & Kurdish</i>	<i>Turkish & German</i>	<i>Turkish & English</i>	<i>Turkish & Kurdish</i>	<i>Turkish & English</i>	<i>Bosnian & English</i>	<i>Bosnian, English & Russian</i>
Counsellor: Gender/Age	<i>Male- 35</i>	<i>Female-</i>	<i>Female- 50</i>	<i>Male- 65</i>	<i>Female- 40</i>	<i>Male- 35- 40</i>	<i>Female- 35</i>	<i>Male- 60</i>	<i>Female- 35</i>
Counsellor: Occupation/Ethnicity	<i>Counsellor / English</i>	<i>Counsellor/ English</i>	<i>Counsellor/ English</i>	<i>Therapist/ Indian & Turkish</i>	<i>Therapist/ English</i>	<i>Counsellor/ English & Turkish</i>	<i>Counsellor/ Indian</i>	<i>Don't Know/ Pakistani</i>	<i>Psychologist /English</i>
Interpreter: Gender/Age	<i>Female- 35</i>	<i>Female-38</i>	<i>Female-40</i>	<i>Female- 44</i>	<i>Female-various</i>	<i>Various-Variou</i>	<i>Male- 30s</i>	<i>Male- 30</i>	<i>Female-25</i>
Interpreter: Ethnicity	<i>Interpreter / Turkish</i>	<i>Don't Know / Turkish</i>	<i>Interpreter / Varied</i>	<i>Interpreter / Turkish</i>	<i>Don't Know / Iranian</i>	<i>Interpreter / Turkish</i>	<i>Interpreter / Turkish</i>	<i>Don't Know / Bosnian</i>	<i>Student / Bosnian</i>

Table 5: Socio-demographic information of the clients.

Recruitment and selection

The clients were approached in two ways: first, through a community organisation that was working with Turkish speaking people who were from different countries, offering a variety of services ranging from educational to emotional support to women, children and men. The organisation was informally approached to explain about the study and to find out if and how they could help, and then formally written to about the details and procedure of the research upon their agreement to take part. The organisation was asked to pass the information on to invite community members to take part in the study.

The researcher further decided to extend the radius of the client recruitment to other cities to reach diverse client profiles. Therefore, as a second way of recruitment, the researcher asked some community members if they know anyone who would be willing to share their experiences through word-of-mouth communication. As a result, two clients were recruited from Leicester, two from London and six clients were recruited in Birmingham. Four of these clients came through the organisation and six through word-of-mouth communication. Most clients were interviewed in the organisation, some in the libraries in their cities and a few in their houses as they had difficulties in going out. A thorough risk-assessment procedure was followed to assess the suitability of the premises, people living in the house and the researcher's own safety.

The staff of the organisation was informed about the criteria for identifying potential participants who had received and/or were receiving emotional support from a counsellor through an interpreter. The staff was asked to direct clients to the researcher or to share clients' contact details, with the permission of the client, with the researcher. However, the final selection of clients was made by the researcher. All documents sent to the clients and the organization were produced in both English and Turkish.

The criteria for the selection of the clients included that the participants were 18 and over and that they had an experience of psychological distress for which they had received, or were receiving, emotional support from a counsellor or other mental health workers through an interpreter. Participants who were actively holding or had been holding any suicidal ideation for the last twelve months, and who had been having psychiatric treatment including long- term psychotherapy were excluded.

Participants who were able to speak English well enough to communicate during the interview were accepted as well as those who could not. Two clients were recruited from a Bosnian background. These participants stated that they had to have interpreters when they were receiving psychological help.

At this point, it should be noted that the participants are addressed as ‘non-English speaking clients’ throughout the thesis, however, this does not necessarily mean that they were unable to use English in their lives at all. It rather refers to the fact that these clients needed interpreters in their encounters with service providers due to their limited language proficiency in English.

How to address foreign language speakers within a host country has been a heated debate for some time. It has attracted several linguists and led them to come up with innovative and evolving concepts. For example, Davies (2003), Rampton (1999) and Llorca (2009) critically evaluated the underlying connotations in the ‘native-speaker’ concept, arguing that it implies exclusion and discrimination. Cook (1999) offered the term ‘L2’ users, referring to people who know more than one language; O’Rourke and Pujolar (2013) proposed ‘new speaker’ that indicates people who are outside of the traditional native-speaker communities (p.56). But all descriptions have drawbacks, leading linguists to continue working on the conceptualisation of it. More recently, Dewaele (2017) has proposed the term ‘LX users’, arguing that LX is a neutral term and includes people who have acquired any second language after the age of 3. There is no order and time scale in the languages acquired as it is in the case of L2 and ‘new speaker’ (p.3).

Researcher’s reflexive observations on the interviews

The individual interviews were carried out with more attention to timing, interference and bringing the topic back to the research questions. Some interpreter interviews became derailed due to the anxiety that perhaps I felt in myself as a researcher and that was felt by some participants. Some of them found it difficult to follow the topics as they were young and inexperienced. Some interpreters had accents and it was difficult to establish their points of view in one attempt. The ones who had had formal training were articulate and therefore talkative and straightforward in expressing their opinions.

In some interviews, though, I myself became a focal point. They reflected some of their political opinions on me. However, I overcame these transference feelings by maintaining

my professional boundaries, and interpreting these incidents as a means of making the conversation lively on the part of the participant.

Counsellor interviews were highly interactive and rich in many senses. Most of the participants were senior practitioners and they wanted to raise the matters that they thought were highly relevant to their fields. However, one of the interviews greatly challenged my understanding: one participant brought the issues discussed back to the historical events by which she linked interpreters and service provision related difficulties to race and cultural issues in general; to slavery and institutional racism, particularly. These explanations surprised and puzzled me, not because of their contents, but of my ignorance that became apparent especially during the transcribing process.

I struggled to give enough weight to the matters in my analyses, and took those to the supervision. My supervisors acknowledged the issue and provided me with further insights, explaining that this finding was an important input and meaningful for the participant. This further motivated me to learn more. I extensively read on race, culture and racism, along with the transcribing and analyses processes. This was a significant experience for me as it shows that researchers may not be aware of their biases, weaknesses or even their strengths, especially when they encountered anything that they were not familiar with. This has also proved the importance of having supervision throughout the process.

The interviews with the clients were also full of surprises for different reasons. I was surprised by the difficulties that I encountered in the recruitment process. I had to travel far to maximize my recruits. However, the client interviews were satisfactory without any concerns. They were apprehensive in the beginning but eventually managed to open. Assuring them with honesty and using the right language proved successful. I was also aware that being a psychologist could make it easy for them to trust. They were articulate enough in their points although they did not talk too much. Therefore, the transcribing process was relatively easy apart from the double translation that I had to produce both in Turkish and English, and getting this checked by someone else.

Overall, the process of data collection was productive and satisfactory. All stages starting from the stage of developing research questions to the final writing-up were exciting, stress-provoking and mostly isolating as McLeod puts it most qualitative research are done by lonely researchers (p.10). Although most of the time, puzzled and uncertain, I have

managed to be positive, appreciating the contribution of the participants and the learning aspect of the study.

Ethical issues

Ethical considerations were given high priority from the beginning of the study to make sure that whoever was involved in the study would be safe and free to express themselves. This was ensured by adhering to the guidelines of the BACP Research Ethics Committee. The ethical approval was sought from the University of Leicester and the application process for each stage was completed well before the data collection.

In total, three ethical applications were made: one for the focus group sessions, one for the semi-structured interviews, and one for the client interviews.

The ethical considerations aimed to provide safety for the participants and the researcher, and acknowledge the rights of the participants in terms of taking part. These rights include providing the participants with accurate and clear information about the whole process, the need for their consent, their right to withdraw, their need for assurance and briefing, and the need for and information about confidentiality and anonymity. The participants were clearly informed in writing that the conversation would be recorded and listened to by the researcher and by the supervisor of the study only, if necessary.

In an attempt to address the needs of any participants distressed as a result of being interviewed, further arrangements were organised. For the clients, a bilingual counsellor, who could speak English and Turkish, was arranged to offer a one-off-counselling session concerning their stress. For the interpreters and counsellors, the counselling organisation, where the interviews took place, agreed to provide a one-off counselling session. All participants were informed about this arrangement beforehand.

The participants were given the contact details of the researcher on the information sheet and informed that the ethics approval had been sought before contacting them. It was agreed with the research supervisor that in any case of publication, another coding will be developed to protect the identities of the participants.

Data Analysis

There are several qualitative research methods that are used to interpret and generate rich and detailed accounts of peoples' experiences. These methods include Grounded Theory, Thematic Analysis and Interpretative Phenomenological Inquiry. However, selecting one amongst these in the 'marketplace of ideas' is an arduous task, as Wolcott (1992) notes.

Most of these analysis techniques to a certain degree function in the same way. They aim to search for the codes and the themes that describe the phenomenon in question within the data after repeated and careful re-readings. But it is still not easy to draw clear boundaries between them. Some authors take the view that this task is a craftsman's job that can be learned in time depending on the skills, motivation and experience of the researcher (Potter, 1997). Similarly, Denzin and Lincoln (1994b, p.2) likened the researcher to a 'bricolage' who skilfully uses the tools necessary to get his or her job done. Going into details of these individual techniques will be beyond the aims of this research. But some of the reasons held by the researcher for choosing Thematic Analysis over the other two contesting qualitative methods will be given.

Rationale for Thematic Analysis

Thematic Analysis (TA) is a technically and theoretically flexible technique, and establishes a foundational method for all qualitative analysis methods and thus has a wider applicability (Braun & Clarke, 2006, 2013). To Boyatzis (1998), TA is a core and set of generic skills for qualitative researchers, and therefore it can be seen as a tool to use across different methodologies. It is possible in TA to carry out analyses and to utilize more than one approach at the same time in accommodating varying findings. It does not necessarily work with and within a particular theory. In addition, TA allows the researcher to be an active and reflexive part of the research process.

In this research, the aim was to obtain information about the internal and external worlds of the clients, the interpreters and the counsellors, finding out both similarities and differences in their insights, feelings and actions, illustrating their varying world views. In doing so, TA was considered as an appropriate way and a lens through which the dynamics of the triadic therapeutic relationships can be looked at from inside the therapy rooms and from outside, at the societal, personal and organisational levels.

In terms of the researcher's theoretical assumptions, researchers nowadays exercise more than one philosophical and epistemological position. However, as Fine (2002) notes, qualitative research does more and argues further than simply giving a voice to the participants. The researcher purposefully collects the data, reads it repeatedly, selects and refines the relevant contents with the arguments made throughout the study. These are achieved by the active involvement of the researcher who thinks about and approaches the topics and the data with and within the phenomena in question.

Some authors argue that thematic analysis offers the researcher the opportunity to take an essentialist, realist or social constructionist stance when reporting the realities of the participants, which fits very much with the researcher's aim of providing the best and most inclusive descriptive and detailed accounts of the participants. Willig (1999) calls this position one of 'critical realism' in which people move around their realities as a result of the external and surrounding factors. Braun and Clarke (2006, p.9) similarly summarized it below:

'Thematic analysis can be a method which works both to reflect reality, and to unpick or unravel the surface of 'reality''.

With regard to why Grounded Theory and Interpretative Phenomenological Analysis were not chosen, the main reason was that they are theoretically bounded. Although these two techniques do not differ very much in terms of how the data is analysed, finding out descriptive, conceptual, semantic and latent codes, they differ in shaping the codes and themes by looking at and interpreting the content according to the philosophical assumptions of the researcher (Braun and Clarke, 2006).

Grounded Theory is concerned with wider and societal phenomena, searching patterns of meanings in the data collected at different times from different sections of the society. In that sense, data collection differs as it requires undetermined data to work on (Glaser and Strauss, 1967), hence works better for large research projects. GT mainly aims to generate a theory as an outcome of the analysis, and to do that, if necessary, a GT researcher may continue collecting data (Corbin and Strauss, 1996; p.15). McLeod (2001; p.89) summarizes that although it is highly robust, pragmatic and a systematic qualitative inquiry, GT is 'a-theoretical and a-historical' and does not address human agency.

The current study aimed to provide a comprehensive and rich understanding of and to produce representative accounts for the overall experiences of the participants. Therefore, developing a theory out of the analyses was not the main motive.

Since Grounded Theory aims to come up with an explanatory theory, researchers are advised not to be heavily informed about the study topics and to have any pre-identified list of concepts by becoming involved in a prior reading of the literature (Corbin and Strauss, 1996). However, the researcher of this study, as a psychologist and an interpreter, felt that she had already read a reasonable amount of literature with regard to issues both in counselling and interpreting fields before starting this research. Therefore, TA seemed to be more suitable.

Interpretative Phenomenological Analysis (IPA) was also not selected. Phenomenology focuses on the person's perception of the meaning of an event (Husserl, 1960). IPA is essentially an idiographic inquiry in which the researcher looks at the data through the eyes of the participants as if he or she is one of them. The researcher then interprets the data to unravel the process of constructing the meaning behind the experiences (Willig, 2001). IPA focuses particularly on the unique characteristics of the participants. Although the current study is aimed at the understanding and searching for the patterns of meanings in relation to participants' experiences, the participants were encouraged to be experiential. The researcher had similar experiences to the participants, but the main aim was not to provide idiographic accounts of the participants' experiences. That is, the focus was not on participants as individuals but on their understanding and meaning-making processes in relation to helping others and being helped.

Interpretative Phenomenological Analysis is a theoretically informed framework underpinned by phenomenology. Smith, Flowers and Larkin (2009) note that IPA offers a whole frame for an analysis starting from ontological and epistemological stances to the sampling strategy and the collection of data. By contrast, TA can be applied by taking positions in between and it can be used for any type of qualitative data.

Both analytical methods focus on the ways in which meanings are constructed and communicated, and how they are patterned within the language and culture. IPA further focuses on the linguistic matters whereas TA may not. In this study, although the main aim was not exploring why and how certain words and concepts were used in terms of their semantic and linguistic content, wider language related issues such as being helped and

helping through translation and interpreting were explored. The researcher took into account the impact of the language in triadic communication and the language as an influential factor in understanding the dynamics when working with non-English speaking clients, but she did not take it to the point where language is regarded as a main construction of people's experiences as McLeod (2001; p. 91) stated, life is not regarded as a 'language game'. The researcher worked on the difficulties that participants varyingly experienced regarding the use or misuse of the language as well as the impact of the absence of the language required.

In terms of methodology, both start with coding and focus on patterns of meanings within the data. The main difference is that in IPA each transcript is coded and noted on its merits, after completing one and then the second transcript is explored. Analysis is undertaken for each data set. But in TA, codes and analysis are made across the entire data sets (Braun & Clarke, 2006). As a final note, it should be emphasized that the end results may still look similar to each other in terms of coding and developing themes.

Transcribing process

The process of transcribing data is claimed to be a significant part of the data analysis and moreover power dynamics can be captured through it (Riessman, 1993; Bird, 2005; Braun & Clarke, 2006). Although there are many different forms of converting conversations into texts, and there are no sets of guidelines on how to do this, some authors recommend that transcription should be produced rigorously with attention to detail, basically a verbatim account of what was said (Braun & Clarke, 2006; Poland, 2002).

Oliver, Serovich and Mason (2005) mentioned two ways of producing transcriptions: Naturalism and Denaturalism. In the naturalistic approach, language is believed to represent the real world, and pronunciation, accent, communication style, speech idiosyncrasies and irregular grammar are viewed as part of participants' life and meaning-making processes. In the naturalistic method, every utterance is captured.

In most conversations, vocalisations other than speech (laughing, coughing, stuttering etc) and non-verbals (hand-waving and smiling etc) are common. Involuntary vocalizations such as sneezing, burping, sniffing, laughing and crying are considered involuntary noises but they still can be meaningful (ibid, p. 1282-1282). Response tokens are intentional vocalizations and there is meaning attached to them. Many tokens such as 'Mm, uh huh,

yeah, huhs' are used to add more detail and /or emotion to what the speaker is trying to express, to note agreement with the speaker or ask the speaker to rephrase or repeat an idea or question.

In denaturalized transcribing, the focus is more on the content rather than the conversation mechanics. Meanings and perceptions that construct the reality are within the speech (Cameron 2001). Although it is still a verbatim depiction of speech (Schegloff, 1997), depicting accents or involuntary vocalization and idiosyncratic elements of speech such as stutters, pauses, and nonverbal involuntary vocalizations are removed (Oliver, Serovich and Mason, 2005).

Kasperek (1983) offered another conceptualisation in transcribing: formal equivalence and dynamic equivalence. Formal equivalence means translating literally and word for word even at the expense of meaning, while dynamic equivalence means translating the essential thought in the original language at the expense of literality and word sequence in the original language (Kasperek, 1983). Translation in the present study was carried out using a combination of both approaches, engaging continuous analytic dialogue with the transcript.

Transcription is part of the interpretation process through which the meanings are continuously made (Bird, 2005). It can be said that, in this stage, initial coding can be made along with the researcher's notes. The researcher tried to analyse the essence of the data from the beginning, starting from writing the research proposal and carrying out the interviews to transcribing the interviews. The process was started by checking the data against the quality of the recordings and aspects such as background sounds and external noises. Then the conversations were listened to twice to get a sense of them and to capture the general points. The notes and initial analyses were recorded on a separate transcription so that the master copy was kept intact. In the counsellors' group, the responses of one participant was later rechecked as the speech was too fast to follow.

All gestures of the participants including backings-and-fillings, false starts, repeated tag questions such as 'Do you know what I mean?', and additional sounds and words like 'Erm, yeah, hmm!' were fully recorded. The researcher tried to keep the original format and be reflective as much as she could by remembering what the authors suggested researchers ask: "Would the transcription look different if the participant were the transcriber?" (Oliver, Serovich & Mason, 2005; Braun & Clarke, 2006)

The researcher initially transcribed the interviews in a naturalistic way in which response and non-response tokens, overlapping talks, and stutters were kept. This facilitated the sense of familiarity with the data. But, during the writing-up, especially when quoting, the denaturalised transcribing method, in which the utterances were kept minimal, yet providing a verbatim record of the conversations, was used. This was mainly to do with keeping the word count in balance and also helping the readers to read the quotes without being occupied by other details that might not have direct relevance to the categories and themes developed.

Wrong usages of the words stated by the clients due to their limited language proficiency both in Turkish and English were not corrected. This kept intact the original formats and meanings although these errors were corrected in the quotes; for example, some clients addressed their counsellors as ‘doctor’, and some interpreters called the clients ‘customers’.

The process of thematic analysis

Fereday and Muir-Cochrane (2006, p.4) describe Thematic Analysis as a process of ‘recognition of patterns’ within the data. It not only identifies and analyses patterns (Braun & Clarke, 2006) but also interprets hidden and subtle aspects of the phenomena concerned (Boyatzis, 1998).

The definitions of the basic terms used throughout the study are as follow: *data* refers to the collected materials throughout any given research; a *meaning unit* is the smallest meaningful segment of a conversation or a text which could be a word, a sentence or even a picture; *categories* are the collection of the meaning units that make meaningful patterns of thoughts related to the topic of a study; and *themes* are the comprehensive picture of participants’ collective experiences developed by researchers (Braun and Clarke, 2006).

In analysing the text to find out the implicit and explicit meaning patterns, there is no one way of doing this, but, as McLeod (2001) notes, a repertoire of methods. McLeod draws attention to the fact that patterns of meanings would not emerge by themselves but come to light through the researcher. He recommends the use of a framework for analysis so that it can prevent the process from derailing and unnecessary early endings. In this study, Braun & Clarke’s (2006, p.87) six-step guide for the thematic analysis were used. These stages are explained along the procedure that the researcher followed.

1. Familiarisation with the data

2. Generating initial codes
3. Searching for themes
4. Reviewing themes
5. Defining and naming themes
6. Producing the report

Familiarisation with the data

Data familiarisation involves getting to know the content of the interviews. If the data are collected by the researcher himself or herself, doing the interviews can provide the basic familiarity. This stage is particularly important as not doing so can lead to unsuccessful attempts in making sense of the data later and a failure to match the themes with the data in the end (Braun & Clarke, 2006; Charmaz, 1998).

The literature suggests that repeated re-readings should be carried out throughout as basic knowledge about the data would be insufficient. It is an ongoing process that requires active ways of reading the data (Braun & Clarke, 2006) repeatedly, at least once, with an attention to the common mistake of selecting a particular part of the data (Willig, 2001).

The researcher made extensive notes about her thoughts, feelings, what went well and what went not so well, and about how she could improve her performance as an interviewer and about others' verbal and non-verbal clues and utterances. Keeping this journal allowed her to reflect on her own approach to what happened before, during and after the sessions. This provided her with a good glimpse of the atmosphere as well as the conversations, even three years later when returning to the transcriptions. All the words, concepts, jokes or colloquial words that the participants used were noted in order to retain the inclusivity and encompassing nature of these concepts.

Some words used by some participants were not clear enough to catch when hearing for the first time as some either talked very fast, mumbling words, or spoke in a low-pitched voice. These moments were recorded. Every incident was reflected upon and every opportunity taken to sense and to know more by re-reading the text several times, day and night, verifying the meaning behind the utterances. McLeod (2001, p.141) describes this internally active process below:

‘Many insights seem almost just to arrive at odd times, for example when walking along a road...!’

Generating initial codes

This stage involves developing discrete meaning units and categories that will lead to encompassing and comprehensive themes. Braun & Clarke (2006) argue that coding is about collating data relevant to each code and it should be done in a systematic way to be consistent.

Anything that sounds different, interesting or even unrelated; certain words and phrases, particularly in cultural and language studies, or anything that might be useful to explain the overall picture in later stages are coded. Tuckett (2005) similarly summarizes this process as an organisation of the data towards meaningful sets of themes. In this study, the name of the places, times, special names, phrases or the metaphors such as 'hot-potatoes', 'smoke screen' and 'blind process' were recorded. The relevance of the codes was regularly checked across the data sets.

The data was approached with an open mind and without a particular theory to frame the participants' experiences. Coding was primarily done manually; but some may prefer to do it using software programmes, some using coloured pens and papers and so forth. The researcher used Microsoft word files making notes on the right-hand side of the pages. Every meaning unit including their frequency of occurrence was coded. In some cases, the same extract was coded for more than one code when further subtle meanings were implied.

How were the meaning units derived?

A meaning unit is a string of text. It expresses a single coherent thought, up to the point at which the coherent thought changes (Graneheim and Lundman, 2004). The analysis starts when a meaning unit is identified. Charmaz (2006) suggests coding quickly and keeping the codes as similar to the data as possible.

In this study, the meaning units were listed in another word file. Each meaning unit was recorded with the line numbers in which it was said, and the name of who expressed the thought. If that meaning unit was repeated more than once, the line numbers were accordingly recorded. This showed the researcher the repeated units clearly and they were quantified later. Significant, even affirmative, responses were counted as meaning units. If the same meaning unit came under a different category, it was separately coded. All meaningful words, terms and phrases including the researchers' own notes after every recording and transcript were noted down verbatim.

The same process was applied to the data sets obtained from the focus groups and the interviews. Data was conspicuously approached, and every effort was made to be as inclusive and comprehensive as possible. All the meaning units were coded in the order of the participants' speech as shown in Table 6.

This table presents the initial significant meaning units that the interpreters used when referring to the nature of the interpreting process. In this part of the interview, the participants were discussing what they thought of the interpreting process or how they made sense of their job. The first column shows where those particular opinions are located within the transcript; the second column shows the identified meaning units, and the third shows the participant who made that point (The names were omitted in later stages).

Line number in the transcript	Initial meaning units with regard to what interpreting jobs involved?	Mentioned by (<i>or its frequency</i>)
117	Interpreting stories and emotions	J (/)
118, 119	Having bond with clients	J, L (//)
124	Being there on time	LE (/)
132	Driving long distances	P (/)
228-229	Dealing with stress	P, AM (//)
262-270	A human activity/not being a machine	AM (///)

Table 6: The initial meaning units derived from the interpreters focus group.

How were the categories developed?

Meaning units that came under the same construct inherently led to the development of categories as the coding progressed. Two types of categories were developed: sub-categories and main categories.

It is important to note that there would be many overlaps and sometimes contradicting meaning units or subcategories; the literature reports these uneven aspects of the data and analysis as a good outcome and normal (Braun & Clarke, 2006). Below is the illustration of the development of the sub-categories after collating meaning units. **Error! Reference source not found.** Table 7 shows the counsellors' views about the presence of the interpreters in the room. The counsellors initially emphasized that interpreters made things easier for the clients and the counsellors, using the descriptions below. The researcher realized that the

interpreters influenced other members of the triad and the process as a whole, thus, designated it as ‘The impact of the interpreter’, classifying it as a ‘Main Category’.

Number of the meaning units	Sub-categories	Main Category
3	Clients identifying with the interpreters	Impact of the interpreter
2	Informing clients about the process	
7	Reassuring the counsellor	
4	Making the counsellor confused	

Table 7: The initial categories derived from the counsellors’ focus group.

Searching for themes

Theme identification or discovering themes is one of the most fundamental tasks in qualitative research. Themes are considered as structures that are often abstract and sometimes ‘fuzzy’ constructs.²¹ Braun and Clarke (2006: p.87) describe theme development as collating codes into potential themes, gathering all data relevant to each potential theme. Leininger (1985, p.60) expands on that:

‘Themes are developed by bringing together components or fragments of ideas or experiences, which often are meaningless when viewed alone.’

All sub-categories and main categories were subjected to a higher level of analytical process in this stage. In different qualitative research methods, themes can be identified at different stages. In this study, themes were based on end analysis of all data sets, which was an ongoing process. Reaching a theoretical saturation can be premature at this stage and it depends on factors like the number of texts and their complexity, the researcher’s experience and the researcher’s fatigue (Strauss & Corbin, 1990). Premature closure could also result from the researcher’s failure or move beyond the face value of the content in the narrative (Wilson & Hutchinson, 1991).

²¹ Ryan, G. W. And Bernard, H.R. Techniques to identify themes in qualitative data. [bernard_techniques_to_identify_themes_in.htm](#)

How were the themes developed?

Theme development is a complex task that takes time and effort and requires knowledge and experience to ground many floating ideas. Themes can be derived from the literature, the characteristics of the phenomena being studied and the professional definitions, from local common-sense constructs, or from researchers' values, theoretical orientation, and personal experience with the subject matter (Strauss, 1987; Maxwell, 1996).

The search for a theme for the current study was a continuous process that emerged from contemplation and reflection on the subject-matter. Extensive general reading on similar topics within the field helped considerably. All categories and themes were checked and discussed with other parties including the supervisors. Many tables and thematic maps were developed to illustrate the tentative themes. At the same time, narrative accounts of the themes were written. Table 8 shows how one of the themes from the counsellors' data was developed. The topics were about what interpreters and counsellors needed for the best practice in the field.

Sub-categories	Main categories	Theme
<i>Developing personal competence</i>	Solutions to managerial / Organisational difficulties	Counsellors' perception of professional issues
<i>Developing organisational competence</i>		
<i>Training</i>	Good practice issues	
<i>Supervision</i>		
<i>Professionalization</i>	Policy development	
<i>Local and national policies</i>		

Table 8: Counsellors' view on professional and personal development issues.

Reviewing themes

Category and theme development are constantly subject to rethinking, reorganization and re-evaluation as the analysis continue. Braun and Clarke (2006) note two levels of reviewing: first data extracts are checked concerning whether or not they match the content of the theme. The theme might be found as poorly inclusive and explanatory. Then a new theme can be created or extracts would be moved around. If satisfied, the second level of reviewing is carried out; this process is the same as the first one but this time reviewing is carried out of the whole data set, checking the validity of the themes and the inclusivity of the thematic map drawn. Several thematic maps in this nature were drawn throughout the analyses, and one of them can be seen in the Appendix 27: One of the Working Thematic Maps. (The Interpreters' data).

In this process, all the data are read again to check if any data are being missed and could be better worded or placed. Therefore, some themes may converge or some may become independent themes (Patton, 1990). Developing evolving 'thematic 'maps' for the data helped the researcher evaluate and monitor the organisation of the findings. In this stage, it is important not to get too involved in endless coding and re-coding. Therefore, researchers are reminded to stop when re-coding adds to refinement of the analysis only (Braun and Clarke, 2006).

Also, the titles of the themes can be quite general in order to be inclusive whereas the names of the categories might be more interesting and diverse. Table 9 shows examples of some categories that were later converted into an encompassing theme.

Theme	Main categories	Sub-categories
'VICISSITUDES OF THERAPY AND INTERPRETING FIELDS'	The third dimension: Interpreters	Facilitator or obstacle?
		Interpreters being traumatized
	Impact of the historical and political issues	Don't remind me about the past!
		Attitudes to be changed
	Jack of all trades!	Use of untrained interpreters
		Working through organizational constraints

Table 9: Reviewing of the themes

Defining and naming themes

Naming themes can be a very complex task as more categories are added, the wider and more inclusive the themes become. Capturing all essential meanings into one construct is challenging. This stage involves conducting more informed analysis when the researcher is satisfied with the developed themes and their fit with all data. The aim is to reach coherent and internally consistent data extracts and themes, then to write narrative accounts to explain and justify these themes. Each theme is defined in terms of what it is about and how it is coherently related to all the data. Braun and Clarke (2006) argue that a theme should not be allowed to do too much for the data, nor should it be too diverse and complex (p. 92). A story should be told about what each theme tells the reader. But, it must be noted that, this mini story should be in line with the whole 'story' of the data sets.

In this study, four themes were developed from the interpreters' data, four themes from the counsellors' and three themes from the clients' data, eleven themes in total. As a result of the further analysis, three further over-arching or super-ordinating themes were developed to assist in the discussion of all the findings in the light of the literature. All the themes are presented at the beginning of the 'Findings' section.

Producing the report

The writing up of a research project aims to produce a tangible and communicable work that can be disseminated across the disciplines. Braun and Clarke (2006; p.87) describe:

‘The final opportunity for analysis... Selection of vivid, compelling extract examples, final analysis of selected extracts, relating back of the analysis to the research question and literature, producing a scholarly report of the analysis.’

This is a highly complex enterprise that requires incorporating many direct and indirect factors into it and includes being sensitive to the needs of the individuals and organisations. McLeod (2001; p.146) defines this stage as the ‘*crisis of representations*’ given that there are multiple and various informants with overlapping, repetitive and yet discrete themes.

In this study, a balance between the writing-up styles has been attempted by using both the first and third person in different sections of the thesis and by inserting reflexive accounts where it added to the analysis. As noted and recommended in the literature, summative accounts of the themes enhance the quality of a qualitative research and therefore the researcher provided short representations of the themes developed at the end of findings section for each data set.

Quality check: Validity and reliability

The truth value of qualitative research has always been an issue when compared to quantitative research. Generalisability, trustworthiness and credibility are argued to be challenging to establish in a coherent way. Active engagement of the researcher is at the heart of qualitative research hence the debates. Willig (2001, p.16) describes validity as

‘...the extent to which our research describes, measures or explains what it aims to describe, measure or explain.’

Being open to various interpretations by different researchers of the same findings makes it more difficult to establish validity and reliability than quantitative research where sets of scores can easily be compared. In qualitative research, only words and concepts can be compared (McLeod, 2001). There are ways of assuring quality in qualitative research. Some authors attempted to produce guidelines for the researchers to follow (Stiles, 1993,1997; McLeod, 1994; Willig 2001), and the main tenets of those include explaining the methods very clearly, presenting sufficient evidence, carrying out member checks, doing triangulation or comparing conclusions and by the researcher being open to new insights (McLeod, 2001, p.184).

In this study, Willig's (2001) three-step guideline was followed towards establishing the validity. She suggests researchers should

- ensure that participants are free to challenge, and if necessary, correct the researcher's assumptions about the subject being investigated;
- collect the data in real-life settings, which increases ecological and external validity;
- engage with reflexivity by being open about his or her role throughout the research.

The researcher observed all these steps and in so doing worked meticulously to inform the participants, her supervisors and the readers about the methods that she would be using, how the analyses would be carried out and be presented, and what her research assumptions were. The ethical guidelines were used to ensure the participants' right to express themselves without fear and to withdraw without any consequences attached. The interviews took place in premises which they were familiar with, where they were safe, which were suitable for the research activity and, also, where they preferred to be.

Additionally, throughout the study, the researcher engaged with the data and her own meaning-making progress by making notes and reflecting on her thoughts and feelings. Moreover, she utilized the supervision sessions to monitor her progress and thought processes, which provided both internal and external validity for the study. In addition, the researcher further approached some of her fellow doctorate students to comment on some data extracts to see if there were any inconsistencies in her coding and theme development, and to reduce her potential biases (e.g. Hill, Thompson, & Williams, 1997).

The second most important tenet of the quality check is the reliability of the findings. Reliability is concerned with obtaining the same answers on different occasions when asked by different researchers (Willig, 2001). This has been a debate in the wider research community as qualitative research is heavily shaped by researchers' philosophical positions, skills and experiences. In that regard, in this study, consistency and applicability are ensured by providing clear and transparent information about which participants will be selected and how they will be recruited, the premises chosen for the data collection, providing verbatim transcripts, checking unclear points with the participants where it was possible, monitoring all methodological processes by meticulous record keepings and sharing emerging outcomes with other colleagues, discussing them with the supervisors, and presenting them in two research conferences.

The researcher acknowledges that coming from a similar employment, educational and ethnic background might impose advantages and disadvantages, and that another researcher could naturally approach and interpret the data differently. However, qualitative research is more than following strict sets of rules. Ignoring its very aim of obtaining the best, true and most relevant findings could be the most serious criticism of qualitative research. McLeod (2001) concludes that balance can be achieved by being scholarly aware of all the processes and underpinnings of the method used. He underlines the integrity and genuineness of the researcher when working on credibility. Stiles (1993) adds that qualitative research should resonate with the readers, empowering participants, researchers and stakeholders.

The previously mentioned personal qualities and aspiration for a rigorous methodological approach enabled the researcher to establish rapport and gain access to the participants lived experiences. This very involvement can however make the outcomes a little less reliable when compared to outcomes of a quantitative inquiry. Because bracketing off (Willig, 2001) in qualitative inquiry is more difficult to maintain, the researcher attempted to balance it by observing the boundaries, keeping reflective notes and having frequent discussions with supervisors and colleagues in the counselling and the interpreting fields.

RESULTS

This section reports the findings of the thematic analyses of the data collected from the focus groups and in-depth interviews that were conducted with interpreters, counsellors and clients. The order of the findings reported in terms of the participant groups follows the order of the recruitment. First, the interpreters, then the counsellors and finally the clients were recruited.

The themes and categories in the tables and the text are presented in a hierarchical order; the categories with the most meaning units are presented first. The number of the meaning units and the number of the participants who contributed to the topic in each category are indicated in brackets. The names that were used throughout are pseudonyms chosen by the participants.

In the following chapters, the findings from all the participant groups will be separately presented in the same order: firstly, the findings from the interpreters' data along with the corresponding quotes will be presented in Chapter 4, followed by those of the counsellors in Chapter 5, and finally the findings of the clients' data will be presented in Chapter 6. In each chapter, the themes will first be presented in a table with an explanation; then main categories, sub-categories and further sub-categories will be explained with corresponding quotes from the participants.

Each section will end with a summative account of the data for each data sets.

Overview of the themes and categories

Below is the summative table for all the themes, main categories and sub-categories that were derived from the three sets of data.

INTERPRETERS' THEMES	COUNSELLORS' THEMES	CLIENTS' THEMES
<p>Theme A: Support and train me (Total meaning units: 258)</p>	<p>Theme A: Dynamics of the triadic therapeutic relationship (Total meaning units: 253)</p>	<p>Theme A: Challenging but a helpful process (Total meaning units: 294)</p>
<p>An uncaring sector</p> <ul style="list-style-type: none"> Consequences of mismanagement <i>Ignoring the client needs</i> <i>Wasting resources</i> <i>Interpreters being penalized</i> Insufficient language services Lack of recognition <p>Interpreters' needs and expectations</p> <ul style="list-style-type: none"> Training <i>Mental health</i> <i>Safeguarding</i> <i>Updating</i> Briefing and supervision Respect and Understanding <p>Requirements: Interpreters</p> <ul style="list-style-type: none"> Linguistic skills and knowledge Confidentiality and neutrality Working safely Linking <p>Requirements: Mental health professionals</p> <ul style="list-style-type: none"> Knowledge of the client's culture Training in working with interpreters 	<p>Counsellors' ways of practising</p> <ul style="list-style-type: none"> Establishing trust and alliance with clients <i>Engaging with clients further</i> <i>Contracting and assigning clients</i> <i>Allowing enough time</i> Handling power relations <i>Setting up the scene and the goals</i> <i>Using a second therapist</i> Regarding counselling as a learning process Further engagement with interpreters <p>An emotional and blind process</p> <ul style="list-style-type: none"> Working with sensitive issues and unknowns Working with cultures, meanings and translations A broken rhythm <p>Clients' characteristics</p> <ul style="list-style-type: none"> Anxious about confidentiality Unaware of the process Dealing with multiple illnesses and issues 	<p>Client characteristics</p> <ul style="list-style-type: none"> Anxious about confidentiality and trust Physically and emotionally unwell <p>How I knew that ...</p> <ul style="list-style-type: none"> They did NOT understand me They understood me <p>Impact of the interpreter</p> <ul style="list-style-type: none"> 'I wish I wasn't here!' 'I felt relieved!' <p>Clients' perception of power and the counsellor</p> <ul style="list-style-type: none"> Who had the control? Having expertise and authority Putting the clients off <p>Evaluation of the process</p> <ul style="list-style-type: none"> Emotional, long and disconnected Helpful and informative

INTERPRETERS' THEMES	COUNSELLORS' THEMES	CLIENTS' THEMES
<p>Theme B: Dynamics of the triadic relationship (Total meaning units: 217)</p>	<p>Theme B: Vicissitudes of therapy and interpreting fields (Total meaning units: 194)</p>	<p>Theme B: Organisational and Good Practice Issues (Total meaning units: 109)</p>
<p>Obstacles to establishing trust Clients' reactions <i>Unwillingness to cooperate</i> <i>Inclining towards interpreters</i> Culture and gender Interpreting and translation Attitudes Clients' well-being</p> <p>Being the third person Interpreters as information providers Traumatization of interpreters Interpreters' emotional reactions</p> <p>Role conflicts encountered Clients' expectations from the interpreters Unexpected disclosures from clients Unexpected remarks by service providers</p> <p>Coping strategies Using own resources Being obliged</p> <p>Counsellors' ways of working Understanding clients fully Working with interpreters closely</p>	<p>The third dimension: Interpreters A facilitator or an obstacle Interpreters being traumatized Interpreters' effect on counsellors Interpreters effect on clients</p> <p>Lost in translation Mismatching translations Untranslatable concepts Interpreters' slants 'I can feel it!'</p> <p>Organizational competence Making interpreters accountable Working within intercultural models Working with communities</p> <p>Jack of all trades! Use of untrained interpreters Working through organizational constraints</p> <p>The impact of historical events Don't remind me of the past! Attitudes to be changed</p>	<p>Expected qualities: Interpreters Language competency Genuineness and empathy Specialization Being accountable</p> <p>Expected qualities: Counsellors Knowledge Interest</p> <p>Other factors Organizational issues Others</p>

INTERPRETERS' THEMES	COUNSELLORS' THEMES	CLIENTS' THEMES
<p>Theme C: Interpreters' perception of their work (Total meaning units:143)</p>	<p>Theme C: Good practice issues and recommendations (Total meaning units: 202)</p>	
<p>Satisfying and challenging A human and helping relationship A dream job! Working through challenges Changes occurring in communication</p> <p>Contextual Interpreting Mental health interpreting Interpreting in other contexts</p> <p>Modes of Interpreting Conduit type Culture broker and advocate</p>	<p>Expected competencies: Counsellors Flexibility & Fairness Self-education Assessment skills Emotional maturity</p> <p>Expected competencies: Interpreters Knowledge on counselling Professionalism with passion Linguistic skills</p> <p>Identified needs: Interpreters Training Recognition Supervision Briefing and debriefing</p> <p>Identified needs: Counsellors Tailored supervision Training and experience</p> <p>Further Recommendations Better promoted courses Networking Leadership</p>	

Table 10: All themes and categories developed from all data sets.

CHAPTER 4: FINDINGS FROM THE INTERPRETERS' DATA

Introduction

This section details the outcomes of the focus groups and the interviews with the interpreters. First, the statistical information will be given and then the socio-demographic characteristics of the participants will be presented.

The themes and the categories developed will be reported in a systematic way with the quotes from the participants. This section will end with a summary of the findings.

Socio-demographic characteristics of the interpreters

This section reports the statistical information of the merged groups which consist of the interpreters who attended both the focus group and the in-depth interviews. The socio-demographic details of this group can be seen in Table 11.

The average age of the interpreters was 40.7. Eight were female, two were male. Two were Asians, three Europeans, two Middle Eastern, one Azeri and one Somali. The average number of languages spoken was 3.3. Four interpreters had short training towards working with counsellors; three stated that they had training towards interpreting and translation; three did not have any formal training. Seven stated that their main occupation was interpreting and translation, one was in a management position, one was a support worker, and one did not respond to this question.

The average length of the stay in the UK was 17.7 years. The average length of working as an interpreter was 6.1 years. All the interpreters in the focus group were working in the healthcare field, two of the five were also working in social and legal fields. Three of the five interpreters in the interview group had received supervision.²²

²² Focus groups interpreters were not asked if they had had any supervision or not.

Socio-demographic variables	Pseudonyms of the focus group interpreters					Pseudonyms of the interview group interpreters					
	Ali	Ameer	Julie	Layla	Parveen		Ann	Diane	Gigi	Jim	Meryem
Gender	<i>Male</i>	<i>Female</i>	<i>Female</i>	<i>Female</i>	<i>Female</i>	Gender	<i>Female</i>	<i>Female</i>	<i>Female</i>	<i>Male</i>	<i>Female</i>
Age	<i>34</i>	<i>48</i>	<i>24</i>	<i>56</i>	<i>47</i>	Age	<i>59</i>	<i>41</i>	<i>35</i>	<i>41</i>	<i>22</i>
Marital status	<i>Married</i>	<i>Single</i>	<i>Single</i>	-	<i>Divorced</i>	-	-	-	-	-	-
Education	<i>Islamic counselling</i>	<i>Midwifery</i>	<i>MSc Psychology</i>	<i>NVQ 1-3</i>	<i>IPSI</i>	Education/Qualification	<i>A-levels</i>	<i>MA in Translation & DBSI Law</i>	<i>Diploma in I.T.</i>	<i>BA Psychology & PGD</i>	<i>BA Accounting & Finance</i>
Main occupation	<i>Teacher, Support worker</i>	<i>Translator</i>	<i>Managing Director</i>	<i>Interpreter</i>	-	Main occupation	<i>Interpreter</i>	<i>Interpreter & Translator</i>	<i>Tutor & Translator</i>	<i>Interpreter</i>	<i>Interpreter</i>
Ethnic background	<i>Pakistani</i>	<i>Azerbaijani</i>	<i>Bosnian</i>	<i>Iran</i>	<i>Asian</i>	Ethnic background	<i>Hindu</i>	<i>Italian</i>	<i>Albanian</i>	<i>Iranian</i>	<i>Somali</i>
No. of other languages spoken	<i>7</i>	<i>3</i>	<i>2</i>	<i>3</i>	<i>4</i>	No. of other languages spoken	<i>4</i>	<i>3</i>	<i>3</i>	<i>3</i>	<i>1</i>
Duration of stay in the UK	<i>8 years</i>	<i>10 years</i>	<i>14 years</i>	<i>40 years</i>	<i>10 years</i>	Duration of stay in the UK	<i>44yrs</i>	<i>15yrs</i>	<i>12yrs</i>	<i>13yrs</i>	<i>11yrs</i>
Duration of work in interpreting	<i>3 years</i>	<i>7 years</i>	<i>14 years</i>	<i>6 years</i>	<i>10 years</i>	Duration of working in interpreting	<i>3yrs</i>	<i>6yrs</i>	<i>2yrs</i>	<i>8yrs</i>	<i>2yrs</i>

Any training received	<i>None</i>	<i>Short trainings</i>	<i>None</i>	<i>Short trainings</i>	<i>Short trainings</i>	Training towards working with counsellors	<i>Short trainings</i>	<i>Yes</i>	<i>Yes</i>	<i>Yes</i>	<i>No</i>
Setting worked	<i>Health/Social</i>	<i>Health</i>	<i>Health</i>	<i>Health</i>	<i>Legal & Health</i>	Supervision received	<i>No</i>	<i>No</i>	<i>Once a month</i>	<i>Monthly</i>	<i>Various</i>

Table 11: Interpreters' socio-demographic characteristics (Focus and Interview Groups).

Findings from the Thematic Analysis

The thematic analysis yielded three themes, thirteen main categories, thirty-six sub-categories, eight sub sub-categories and six hundred and forty meaning units in total. The themes are titled ‘Support and Train Me’, ‘The Dynamics of the Triadic Relationship’, and ‘Interpreters’ Perceptions of their Work’. The themes and the categories with the corresponding quotes from the participants are presented below.

Theme A: Support and train me

This theme concerns the challenging and the demanding nature of interpreting jobs and the interpreting field. The main categories cover the areas of the difficulties experienced in the interpreting sector including the interpreters’ needs, and the skills that interpreters, service providers and mental health professionals should possess and employ when practising. Theme A consists of four main categories, twelve sub-categories and six further sub-categories with two hundred and fifty-eight meaning units. They are presented in Table 12.

THEME A: ‘Support and Train me’			
Main categories	Sub-categories	Sub sub-categories	Number of Meaning Units / Number of Participants
An uncaring sector	Consequences of mismanagement	Ignoring the client needs	<i>17/7</i>
		Wasting resources	<i>13/3</i>
		Interpreters being penalized	<i>11/2</i>
	Insufficient language services		<i>25/8</i>
	Lack of recognition		<i>19/4</i>
Interpreters’ needs and expectations	Training	Mental health	<i>16/5</i>
		Safeguarding	<i>14/7</i>
		Updating	<i>13/6</i>
	Briefing and supervision		<i>25/7</i>
	Respect and understanding		<i>15/5</i>
	Linguistic skills and knowledge		<i>22/7</i>

Requirements: Interpreters	Confidentiality and neutrality	20/7
	Working safely	12/7
	Linking	5/3
Requirements: Mental health professionals	Knowledge of the client's culture	17/4
	Training in working with interpreters	14/4

Table 12: Theme A (Interpreters): 'Support and Train Me'

An uncaring sector

This main category illustrates how interpreters work in a sector which is not highly regulated and monitored, and experience support given to them as scarce. The interpreters reported frustration over managerial and organisational issues that had had a significant impact on them. They elaborated on difficulties and challenges that they had had to deal with at an individual and organisational level. Their responses show that managing the nuances of organisations was challenging, resulting in their feeling unsupported, lacking in confidence and wasting resources. These matters are explored in three sub-categories and further sub-categories.

- Consequences of mismanagement²³ 41²⁴/7²⁵
- Insufficient language services 25/8
- Lack of recognition 19/4

Consequences of mismanagement

The interpreters shared that they suffered from the organisational incompetence and managerial problems that impacted them and the therapeutic relationship. They strongly voiced their frustration about how the work was handled in the system and the personnel involved in the system. They equally presented sincere concern over wasted resources. Three further sub-categories outline these matters:

²³ This category has further sub-categories.

²⁴ The number of corresponding meaning units.

²⁵ The number of participants contributing to the topic.

- Ignoring the client needs 17/7
- Wasting resources 13/3
- Interpreters being penalized 11/2

Ignoring the client needs

They argued that a failure or even unwillingness to acknowledge the needs of clients was an indirect outcome of the lack of proper service provision. They reported three types of clients' needs or rights that were commonly missed: speaking in their preferred language; having the same interpreter during the intervention/treatment; and being able to trust the service provider and the system. The participants highlighted that interpreting agencies did not always pay attention to language or to the dialect match between clients and service providers.

‘...they said that [interpreters]²⁶ speak a particular language, but they do not...and you know sometimes there is a person so sick that one need to attend as soon as possible...’(Parveen-88)²⁷

In mental health interpreting, the need for the same interpreter was critical for continuity. Participants argued that failing to do so could have an adverse effect on the clients, undermining their trust in the healthcare staff and the services offered. It could also lead to anxiety.

‘...if the patient is happy with the interpreter, the interpreter should be coming back because it can be unsettling to see different faces every week.’(Diane-417)

It is reported that one-off ad-hoc interpreting ‘as and when’ costs more to the service providers than the cost of the same assignment being completed under a service provision agreement (Stallabrass, 2005).

²⁶ The insertions within the brackets were made by the researcher to clarify the speaker's point.

²⁷ These numbers refer to the line number of the conversation within the transcript.

Wasting resources

The interpreters expressed concern that organizational or agency-related mismanagement resulted in clients, who desperately needed help, losing their bookings and wasting staff time. Unnecessary bookings and/or booking two interpreters for the same client were not uncommon practices, which the participants argued was a waste of time and money. Ali explains:

‘...his time is being wasted as well as mine. And there was another person who waits to be seen...so because of a little mistake, he had to come back again...’(Ali-455)

Some interpreters claimed that their time was wasted by having to wait in queues. This resulted in being left with less time to complete their task, despite attending their bookings on time. Ameer suggested a solution for reporting attendance.

‘...Either they should make information [available] for the interpreters [beforehand] or make a separate queue, [so that] they can quickly start doing their job...’(Ameer-177)

Interpreters being penalized

The participants claimed that one adverse impact of mismanagement was that it was financially costly for the interpreters too. They argued that in addition to being traumatized by client stories or being caught between managerial difficulties, they experienced a fear of being complained about, of not being paid or of being struck off the interpreter register. Layla reported that she was warned about inappropriately signed job sheets by office staff, which was not her fault. Ameer shared her experience of being chastised when she extended her conduit role to an advocate interpreter role when she asked for further help on behalf of the client.

‘I got a call [from the agency] that I was rude. And I had to give a statement...I wasn’t rude, I was trying my best for her because she’s an old lady, she has a daughter and she’s blind...since that time, the agency has never ever given me a job...’(Ameer-232)

Saving money especially in the National Health Service (NHS) has been the top priority across the UK in the recent years. The cost of providing language services to non-English speaking patients has soared (Costa, 2011; Gan, 2012). The cost of interpretation was found to be higher than the cost of written translation. The interpreters in this study indicate wide spread ineffective utilization of the services. Their responses along with those of policy makers and commissioners (Sashidaran, 2003; Ward and Plamer, 2005a) suggest that sensitive and tailored service provision is key.

Insufficient language services

The interpreters shared their concerns regarding insufficient, untailored and mismatching language services in their communities. They reported the use of untrained or ad-hoc interpreters and agencies providing interpreters who did not speak the language or dialect of the clients. But, for some, this was inevitable. Julie made her case with regard to newly-establishing communities, arguing that in some communities it was difficult to find an interpreter with the right language skills:

‘...I have done this job when my family came [over]...you had to do it, because your parents do not have anyone to call upon and the services are not offered or nobody speaks the language.’(Julie-116)

The use of unqualified interpreters or of interpreters who lacked language skills was a common concern. In addition to giving incomplete interpretation to clients and service providers, the participants warned about missing crucial parts which resulted in an incorrect interpretation.

‘...Can you imagine, what would happen to the woman who is expecting and there is a wrong interpretation is being given!?’(Parveen-88)

They expressed concerns about booking an interpreter with the wrong language or dialect, which was likely to result in failure, hinting that interpreting agencies may not always be meticulous about the quality of the service they provided.

Language barriers and inequalities can hinder clients in accessing healthcare services (Fiscella, Franks, Doescher and Saver, 2002), including preventive mental health services. With regard to ad-hoc interpreting, the use of friends and family members is not an

accepted practice. They tend to disregard subtle linguistic forms within the languages and communication (Buhrig and Meyer, 2004). However, families and friends are likely to be more culturally aware and sensitive with a greater ability to address the patient adequately, by being not too technical or too direct (Turton, De Maio and Lane, 2003; Buhrig and Meyer, 2004).

Lack of recognition

This sub-category concerns the managerial difficulties that were encountered by the interpreters. These include the staff having an unprofessional manner towards the interpreters, a lack of respect for and recognition of them, and inadequate remuneration. They were highly critical of reception staff's dismissive attitudes, including disrespect for the interpreters, for example, not providing comments on the interpreters' performance, and sometimes making degrading remarks on interpreters' job sheets. Parveen reported some examples of their behaviour:

‘...It depends on their mood. They [the staff] probably had a bad night, so they probably be next day in grumpy mood! ...’(Parveen-782)

Normally, the service provider who saw the client with the interpreter would sign timesheets with their comments about the interpreter's linguistic and behavioural performance. The interpreters criticized the common practice of interpreters' job sheets being signed by staff who were not in the consultation room with the patient and the interpreter.

‘...I keep having these memos [from interpreting agencies];
‘Receptionist shouldn't sign your form, the person who sees you
[should]...’(Layla-760)

Some staff showed their discomfort when the client showed an interest in the interpreter. This was often about establishing initial communication rather than talking about their problems. Ameer did not understand why staff were suspicious of this initial rapport.

‘...he is asking something [like]... ‘Do you have a toilet here?’ You say ‘No’, [Staff] asks: ‘What did he ask?’...You know, it is upsetting...’(Ameer-619)

The interpreters were also dissatisfied with low pay which Parveen linked with the lack of respect and support.

‘... Agencies cut your money...some say: ‘That’s it.’ Even if you are booked for 2 hours they pay you for 1 hour. They take the money off you.’(Parveen-792)

Fatahi, Mattsson & Skott (2005) found that although consultations through interpreters were invaluable and expensive, interpreters were subjected to unwelcoming and patronizing attitudes by healthcare staff and hence felt internal conflict and anxiety. Valero-Garces (2005) urged interpreters and translators to fight against lack of recognition and inadequate remuneration in the field.

Interpreters’ needs and expectations

This main category underlines another salient theme that emerged throughout the interviews. It reveals interpreters’ long-term aspirations for professional recognition and expectations of opportunities of personal and professional development. Working with people with limited English requires skilled professionals who need on-going training and supervision. The following are the areas for improvement suggested by the interpreters for both themselves and counsellors to facilitate a better triadic relationships and therapeutic outcomes. The participants’ responses yielded three sub-categories:

- Training²⁸ 43/10
- Briefings and supervision 25/7
- Respect and understanding 15/5

Training

The participants’ responses revealed that the interpreters lack training that includes many aspects of work in the health care system. Interpreters thought that training could save them time, lead to more jobs and provide them with a sound understanding of issues. They identified three areas for training:

²⁸ This category has further sub-categories.

- Mental health 16/5
- Safeguarding 14/7
- Updating 13/6

Mental health

The interpreters were aware that working in the mental health field with mental health professionals required them to acquire specialist knowledge. They needed to learn about counselling/therapy, what mental health interpreting required, common mental health problems and available mental health services. Ann highlighted her need for more information about her client's condition.

‘...if we have training... we [would] know how to handle that person...if I knew that she was mentally ill...I wouldn't do that.’(Ann-368)

Maryam needed more information on how counsellors worked.

‘They should learn what counsellors do...what their job is, their skills and... who counsellors are. They should know about their background to be able to get that point.’(Maryam-200).

Diane summarized that using interpreters who have not undergone proper training can give rise to all kinds of unsatisfactory outcomes.

‘...the problem we have that not all the interpreters are actually qualified... sometimes the quality of the interpreter is not looked for, they just want to cover a job. That's where the problem comes along...they don't even know how to interpret in the first person or the third person.’(Diane-371)

Doherty, MacIntyre and Wyne (2010) argue that mental health interpreting is significantly more demanding and emotionally intense than any other setting, and that mental health work typically involves the interpreter listening to and communicating very difficult information including diagnosis, prognosis and histories of trauma and abuse. In

therapeutic contexts, the interpreter is undoubtedly drawn into a therapeutic relationship in a way that is different from other fields.

Safeguarding

Interpreters were keen to work safely and professionally. They were aware that trained interpreters can set the boundaries both for themselves and for their clients. Working safely and practising within the remits of the guidelines are vital. These issues are particularly important in mental health settings where interpreters do not know what to expect. Interpreters need similar training to that which clinical professionals receive. Julie explains:

‘...if you do not have that clinical training to desensitize yourself, then you have to create mechanisms of your own...There is no briefing for safeguarding...As far as I am aware there is no set training ...’(Julie-347)

The National Council on Interpreting in Healthcare, NCIHC, (2010) sets standards for best practice for healthcare interpreters which include accuracy, confidentiality, impartiality, respect, cultural awareness, role boundaries, professionalism, professional development and advocacy (p.7). Likewise, safeguarding issues were of a concern for professionals working with victims of torture and trauma. Training on safeguarding should cover how to handle sensitive and traumatic cases. Lipton, Arends, Bastian, Wright and O’Hara (2002) propose guidance on how to provide debriefings for interpreters and the organisations representing them through external debriefings to protect the confidentiality of the clients.

Updating

The work of interpreters is often isolated. They explained that since they hardly talked to other interpreters or the agencies regarding their difficulties, they felt that training to update their skills could be as beneficial as other important courses. They should be reminded of their roles and remit. The respondents argued that they ought to have opportunities to renew their knowledge and skills by attending courses offered by relevant institutions and interpreting agencies. Ann hinted at how important training is for her confidence.

‘...I just need little bit of training...I won’t let them [service providers] down...’(Ann-415)

Jim added that staying in the field without up-to-date knowledge was not best practice; updating themselves was a requirement and a responsibility.

‘...some of the interpreters [were] trained 10 years ago, but still using same experiences or same methods. But nowadays a lot of things have been changed...’(Jim-243)

The literature suggests that the more experienced the interpreters are, the more they believe in training both for themselves and the providers (Granger & Baker, 2003). Miller et al. (2005) suggest that the content of training for interpreters must include topics such as theory and methods of common psychotherapy approaches, treatment strategies for trauma and torture, mental health problems that are common amongst refugees, the nature of complex emotional reactions in the therapeutic triad, and the strategies for self-care (p.36).

Briefing and supervision

The interpreters expressed a need to be informed about the assignments and about the clients with whom they will be meeting. When this introduction is denied, interpreters become more vulnerable. A short briefing about the client’s concerns would allow interpreters to be prepared mentally and linguistically. Julie explains:

‘I think the interpreters... need to be briefed before this kind of sessions and at the end of the session [to be]de-briefed again...because some of the sessions can be extremely exhausting.’(Julie-179)

The participants were keen on having regular supervision as they were aware that counsellors had lacked time. They felt that even talking to a mental health professional after a hard session could be beneficial. Diane extends the benefit of supervision to checking interpreters’ well-being;

‘...I think the counsellor should actually spend a few minutes with the interpreter asking if they need to talk about...if there was anything that upset them. Because we are all human beings and yes we have to

provide a certain kind of service but at the end of the day what we hear stays with us.’(Diane-I196)

The interpreters found the research interviews supportive: an opportunity to express their feelings. Molle (2012) similarly found that her participants found it highly therapeutic talking to her as a researcher regarding their interpreting experiences of working in a secure mental health hospital.

Costa (2011) recommends that they should be receiving both managerial supervision and professional support and mentoring. She asserted that interpreters were often bystanders witnessing and communicating intense and distressing material, yet were unable to take any action to provide relief.

Tribe and Morrissey (2004) note that there is an attitude of knowing ‘how to do it’, which hinders mental health workers’ potential to benefit from working with interpreters. Holmgren, Sandergaard and Elklit (2003) found that interpreters were in favour of organising better coordinated communication between various occupational groups, and regular meetings with the same staff to be adequately debriefed, and that 80% of them expressed their need for supervision (p.27). ‘Good practice’ guidelines for psychologists working with interpreters state that interpreters are entitled to support and supervision in the same way that mental health practitioners are, and that a duty of care applies (BPS, 2008).

Respect and trust

Lack of professional recognition was a concern for the interpreters. They expected to be respected and trusted. They claimed that interpreters did not receive appropriate and sufficient support from the agencies and organisations nor did they appreciate their work. Parveen rightly worded it as ‘trust for all and from all’, arguing that trust should not only come from the service providers but also from the clients in terms of clients trusting interpreters in relation to their linguistic competency.

‘...trust, and the other party who you are interpreting for has actually gotta have a faith in you...about what you are gonna say...’(Parveen-82)

Tribe with Sanders (2003) and Hwa-Froelich & Westby (2003) have drawn attention to the lack of professional identity and regulated training for interpreters. It is a concern that interpreters are regarded by some as ‘technical tools’ (Holmgren, Sandergaard and Elklit, 2003), a ‘necessary nuisance’ (Tribe and Thompson, 2009), an ‘unfortunate necessity’ or a ‘potential obstacle’ to the therapeutic encounter (Miller et al., 2005). These views are argued to lead to dissatisfaction with their work, a reduction in the motivation to take on further assignments and an unwillingness to engage with clients and the process. Miller et al. (2005) summarised that interpreters expect their perspectives to be heard and documented as a way of countering the historical inattention to their voices within their agencies and in the clinical literature (p. 38).

Requirements: Interpreters

This category reports what skills and professional standards interpreters were expected to hold and present. These professional standards and skills were not only linguistically but also socially important and expected to be observed at all times. Interpreters ought to have knowledge of the host culture, understand the organizational culture and have social skills to engage. These requirements are presented in four sub-categories:

- Linguistic skills and knowledge 22/7
- Confidentiality and neutrality 20/7
- Working safely 12/7
- Networking 5/3

Interpreting is more than simply translating what is said: it is about processing the information mentally and linguistically and preserving the expression, the content and the intent. The participants argued that interpreters should recognize subtle codes and specific terminology in the target and the source languages, and identify overt and covert meanings. Ali underlined the need for good attention skills in grasping the clients’ verbal and non-verbal clues.

‘...especially facial expression...I need to understand his gesture, posture and his body language to understand what he wants to say...’(Ali-32)

Layla and Diane asserted that interpreters should have the curiosity and the willingness to get to know and to help the client.

‘...know about how have they been here, about their family...and you...have this little friendly conversation...’(Layla-66)

‘...you have to be ready and willing to help. Otherwise, you should really do something else...’(Diane-227)

The NCIHC (2011) notes that interpreters must possess a wide range of communication, interpersonal and ethical decision-making skills, including active listening, message conversion, and clear and understandable speech delivery skills (p.5). Miller et al. (2005) argue that mental health interpreters should have core qualities as therapists do such as ability to show empathy and a high level of psychological mindedness. They are also expected to have a strong sense of duty, and a high level of linguistic proficiency with a large vocabulary and encyclopaedic knowledge (Xu, 2006; Zhang, 2011).

Confidentiality and neutrality

Interpreters emphasized the need for an increased awareness and experience in relation to confidentiality and safeguarding issues. Confidentiality requires not sharing anything about the client with anyone outside the team, particularly not in the community or amongst other interpreters. They were aware of the difficulties that they would encounter, particularly in small communities in which everyone knows each other. Clients might be a little apprehensive, knowing that their story is known by someone in their circle, especially in the case of sensitive matters.

‘...if you break the confidentiality and taking the information from therapeutic sessions to outside, I think, that ethically is not acceptable...’(Jim-309)

Confidentiality is argued to be one of the most important codes of conduct that interpreters should observe at all times during and even after assignments (Bjorn, 2005) and they are also the ethical requirements for interpreters as well as for other practitioners (BPS, 2008).

Working safely

Participants stressed the importance of maintaining space and operating safely within that space. This involves not being too close to the client or the provider and following the professional guidelines set by the regulatory bodies such as the NHS, BPS and BACP. Coming from the same community, and therefore sharing the same language and culture, could lead to further dynamics. Since interpreters are known in their communities for their linguistic and other skills, this makes them highly vulnerable to be turned to if further help is needed. Making this professional boundary clear to clients is not an easy job:

‘...I know, it mainly come across like [being] rude...but you’re here not to know, not to exchange telephone numbers...you’re here to provide a service.’(Diane-382)

In case of over-identification or being inexperienced, the interpreter might feel insecure to respond to declining clients’ personal questions or demands from the interpreter. Cambridge (2002) stated that complex emotional reactions towards the interpreter could hinder the observance of the professional code of neutrality.

Linking

The interpreters acknowledged that they needed to be part of a regulatory body such as ITI (Institute of Translators and Interpreters) for safeguarding reasons as well as for personal development. Linking with an organisation would provide them with potential sources for finding solutions to various difficulties encountered. Some participants argued that being isolated from the professional circle led them to suffer in silence. They needed to unite to be able to seek further assistance, and for their voice to be heard when tackling challenging issues.

‘...if you are not affiliated with an organization. It is easy to step into that trap when you just being a nice human being.’(Julie-388)

Interpreters have long been advocating the establishment of a union to combat representation issues (Holmgren, Sandergaard and Elklit, 2003; BPS, 2008). Some local organisations have been trying to ease the pressure by bridging the needs of clients, clinicians, interpreting organisations and health care organisations (Costa, 2011).

Requirements: Mental health professionals

This category reports the views of the participants about what mental health professionals should adhere to and demonstrate in their pursuit of providing efficient and satisfactory services. An effective therapeutic relationship depends on how each member of the triad perceives each other, how much they are prepared to enable the relationship to work and if they see or experience any gain during and after the sessions. The participants argued that this process also required mental health practitioners to have relevant knowledge and skills for better therapeutic outcomes. These areas are summarized in two domains:

- Knowledge of the client's culture 17/4
- Training in working with interpreters 14/4

Knowledge of the client's culture

The participants explained that working in a multicultural society would inevitably lead to see clients from all sorts of backgrounds from all over the world with unique characteristics of their cultures. Working with and within these frames would impose many challenges. One of the ways of dealing with these difficulties was that if counsellors had information about the client culture and obtained a priori information about the community they will be working with and having a good grasp of clients' cultural backgrounds. This was to improve the level of engagement with their clients. If not, according to Diane, providers would find it difficult to explore clients' inner world.

‘...some counsellors stick to their script... and they don't listen to the needs of the client...’(Diane-230)

Communicating emotions across languages and cultures can result in messages or meanings being dismissed, distorted or totally ignored. Messages may get lost not only due to language barriers but also due to the staff's readiness and preparations for work (Bhui and Bhugra, 2004). Bhui and Morgan (2007) argued that when the therapist does not present himself or herself as culturally sensitive, this creates friction and anxiety that might result in poor adherence to the course of interventions.

Training in working with interpreters

Interpreters argued that their experiences made them realise that mental health practitioners also needed additional training in understanding how interpreting and interpreters work. They claimed that, thus, some counsellors did feel comfortable when the third person was present, and that knowing how the three-way relationship worked helped them greatly. Diane summarized some of the dynamics:

‘...the counsellor doesn’t know what is happening, because sometimes, I believe, the counsellors are confused about the role that an interpreter has.... I think that they should be taught first of all how interpreters work. Because the interpreters should interpret in the 1st person....and [when I do that] some professionals think that ‘I have [got] the problem!!’(Diane-105)

It has been argued that working with interpreters can cause anxiety, be overwhelming due to moving from the dyadic relationship to the triadic one (Raval,1996). Stolk, Ziguras, Saunders, Garlick, Stuart and Coffey (1998) reported that mental health professionals showed more readiness when they were trained in how to work with interpreters. Tribe and Morrissey (2004) also note that mental health professionals are not keen on receiving training themselves even though they promote it for interpreters and working with trained interpreters provides invaluable information and further skills to mental health. Miller et al. (2005) further suggest therapists training cover the functions of relational and ‘black box’ models of interpreting, recognition of clients’ attachment to interpreters, interpreters’ flexibility in their working models, and educating interpreters about specific therapy techniques used (p.36).

Theme B: ‘Dynamics of the triadic relationship’

This theme concerns the ways in which the interpreters viewed the triadic therapeutic relationship. Their responses illustrate how the three-way relationship effectively worked or how it did not; how the interpreters were frustrated, what the hindering factors were, and how the counsellors attempted to establish a working alliance and maintain a bond and trust with clients and interpreters. The theme further reports the challenges that interpreters and clients encountered. Theme B consists of five main categories, fifteen sub-categories, and

two further sub-categories with two hundred and seventeen corresponding meaning units as seen in Table 13.

THEME B: Dynamics of the triadic relationship			
Main Categories	Sub-Categories	Sub Sub-Categories	Number of Meaning Units/ (Number of Participants)
Obstacles to establishing the trust	Clients' reactions	Unwillingness to cooperate	15/5
		Inclining towards interpreters	12/4
	Culture and gender		23/8
	Interpreting and translation		17/6
	Attitudes		16/3
	Clients' well-being		9/4
Being the third person	Interpreters as information providers		19/5
	Traumatisation of interpreters		17/9
	Interpreters' emotional reactions		13/7
Role conflicts encountered	Clients' expectations from the interpreters		11/5
	Unexpected disclosures of the clients		11/4
	Unexpected remarks from the service providers		9/3
Coping strategies	Using own resources		13/5
	Being obliged		11/3
Counsellors' ways of working	Understanding clients fully		12/7
	Working with interpreters closely		9/5

Table 13: Theme B (Interpreters): 'Dynamics of the triadic relationship'

Obstacles to establishing trust

This category concerns the ways in which trust and a working alliance were established with an emphasis on the obstacles in achieving it. Being able to trust, communicating effectively and a willingness to work are the key components in any therapeutic relationship, and this process can take different directions and forms. It can be affected by individual, organisational and societal factors. Since counsellors tend to work with limited

resources when working with refugees, adding the third party and clients' practical and emotional needs to the frame could be a threat to good counselling practice (Century, Peavey and Payne, 2007).

The presence of an interpreter can create positive feelings and provide trust and safety for clients if they are sensitive and provide cultural information as well as a true translation of what is said. The participants' responses highlight a wide range of factors that affect establishing trust and a working alliance in the five sub-categories. Interpreters reported that these obstacles had an adverse impact on their motivation and performance; these include cultural issues, language-related matters, other members' communicative behaviour and clients' well-being.

- Clients' reactions²⁹ 27/5
- Culture and gender 23/8
- Conduit interpreting and translation 17/6
- Attitudes towards interpreters 16/3
- Clients' well-being 9/4

Clients' reactions

This subcategory illustrates how dynamic therapeutic triadic relationships can be. It has been acknowledged that services offered may not always be appropriate and as inclusive as they should be, particularly for people from ethnic minorities, but clients are still expected to utilize the services and adhere to the interventions offered. Clients may not want to receive the services for a variety of reasons; they might reject and criticise the services by responding in certain ways. Two types of communicative behaviour shown by the clients are illustrated:

- Unwillingness to cooperate 15/5
- Inclining towards interpreters 12/4

²⁹ This category has further sub-categories.

Unwillingness to cooperate

This sub sub-category highlights some client responses to the process, and their influence on the therapeutic relationship. The interpreters observed that the clients tended not to engage when they felt they were not listened to or understood. Then they became unwilling to reveal or share their problems, keeping information to themselves. There are other cases in which clients refuse to talk to interpreters just because they come from the same country or region.

‘...with people who don’t speak English....it’s very stressful. It takes a lot of courage to put yourself on the spot...to actually express your feelings.’(Diane-284)

Asylum seekers and refugees found it hard to trust authorities due to coming from war-torn countries and what had happened to them there. Coming from the same country might make them think that the interpreter represents the authorities of their country of origin. Clients’ unwillingness to cooperate could also be a result of lack of confidence, having no knowledge of available services, and being in isolation.

Inclining towards interpreters

Interpreters claimed that client apprehensiveness as a result of feeling alienated could make some clients want to get closer to the interpreter than the service provider. This can be attributed to having a shared language and culture.

‘I do feel that they are more comfortable when they are talking to me in their own language...I remember one of the sessions, client was totally turning and talking to me rather than the therapist...(Jim-149)

Some argue that it is more than simply being attracted by the language. Hsieh (2006a) notes that it can be the outcome of a learning process through the interpreter or seeing the interpreter as a confidante. Feeling closer to the interpreter nevertheless is likely to put pressure on the interpreter to do more for the client and this can easily lead to role conflicts (Mirdal, Ryding, Essendrop and Sondej, 2011). Century, Leavey and Payne (2007) reported that counsellors felt their work was ‘compromised’ and ‘inferior’ due to the presence of the third person and a lot of effort needed to achieve a satisfactory outcome.

Culture and gender

This sub-category illustrates the ways in which culture is reflected in clients' lives when working therapeutically. The interpreters shared their frustration about cultural issues of which they were not aware. Diane expanded on the complexity issue by noting that even sharing the same language may not provide common cultural understanding:

‘...even if...they speak French, they don't have a French background, as culturally speaking they are mainly from African French speaking country...and obviously the culture is extremely different...’(Diane-34)

These issues reportedly had significant importance in people's perception of reality and mental distress (Helman, 2000) as constructed through language. Emotions are similarly argued to be embedded within the language that provides the constructs and vocabulary to people (Ozanska-Ponikwia, 2012). Tribe and Tunariu (2009) argue that gender politics and associated roles may have an impact on the members of the triad with or without them realizing it. Client behaviours can be understood by knowing their cultural code of meanings and practices. Ali and Parveen's accounts illustrate societal patterns:

‘...it is very hard to understand ladies, because we cannot ask some questions... we cannot touch them.’(Ali-474)

‘...in Asian culture, it is very important that women do not have eye contact directly to the other person...’(Parveen-670)

Some theorists note that there is a complex relationship between culture, language and psychotherapy's hermeneutic applications (Gergen and Kaye, 1992), and that language not only transmits meaning but also constructs and shapes it at both the individual and the societal level (Anderson and Goolishian, 1992; Burr, 1995).

Attitudes

The interpreters reported the adverse impact of the attitudes of service providers and clients towards interpreters, arguing that the main reason for it was viewing them as obstacles. Using interpreters can be highly beneficial to the service providers, but the participants claimed that it was not always the case, reporting disrespectful attitudes of some staff. Most

participants clarified that poor attitudes were mainly presented by other health care staff not the counsellors:

‘...the receptionists everywhere. They treat us like third [class]sort of person...’(Ameer-293)

Some participants however described the counsellors’ approach to clients and interpreters as less empathic than one would expect. Boss-Prieto, de Roten, Elghezouani, Madera & Despland (2010) underline that interpreters and therapists have a different understanding of alliance, and that therapists’ understanding of alliance was quite different from that of the interpreters. Tribe and Thompson (2009) argue that the main reason for clinicians being unsure about working with interpreters was the lack of experience and support they received. It can also be related to the fact that service providers work within time constraints and may not always acknowledge the necessity of briefing both the client and the interpreter.

Interpreting and translation

Working through translation in an interpreted mediated communication was felt as a factor hindering the therapeutic relationship. Clients from different backgrounds imposed new challenges for mental health professionals and interpreters because, as Tribe and Morrissey (2004) note, translating between languages could mean translating between separate worlds and views. The interpreters emphasized the importance of using the right mode of interpreting, particularly in mental health as it goes beyond words:

‘...there’s so much more than the words, when you say it, you know...your tone and your body language...the whole meaning behind it.’(Julie-644)

Interpreters are expected to convey clients’ meaning systems and feelings in highly-charged sessions. There are different linguistic patterns in different languages and this makes translation more difficult when conveying value-laden meanings. Parveen illustrated the diverse nature of the languages in terms of grammar and word construction:

‘...so, the doctor is looking at you, thinking, ‘Now, she will say the patients in 3-4 sentences.’ But I finish it often in 3-4 words. He’s

thinking ‘Hang on, it is not correct because I said so many things...’(Parveen-955)

Hoffman (1998) argued that languages were not interchangeable, and certain words might not exist in other languages. Engstrom, Roth and Hollis (2010) studied what happens when working with torture-affected clients through interpreters. They found that the clinical process was affected by inaccurate translation of the material.

Clients’ well-being

This sub-category concerns how the well-being of clients influences the therapeutic process and the outcomes. Clients presented both physical and mental illnesses. The most common mental health related diagnosis that asylum seekers and refugees were given was post-traumatic stress disorder. Clients’ physical health also took a toll on their well-being and their adherence to interventions. Maryam for example highlights the impact of clients’ mental health on their utilization of the services:

‘...They see it as cultural...when they are in a mental health institution, they feel like they are not there, they feel like there is no such thing! ...sometimes they will be like ‘I am not mental’...When there is a lack of information...they think they are fine...’(Maryam-111)

Being the third person

This main category illustrates the ways in which interpreters influence the therapeutic process and how they are affected by both the interpreting and the therapeutic processes. It also reports how the interpreters felt and reacted to the emotional ordeal they had to deal with. Faust and Drickey (1986) view the three-way relationship as three dyads or ‘communication partners; ‘therapist-client’, ‘interpreter-client’, and ‘therapist-interpreter’. Facilitating two strangers to develop a therapeutic alliance by bridging their languages and cultures is challenging. The responses of the participants towards how they perceived themselves are presented in three sub-categories below:

- Interpreters as information providers 19/5
- Traumatization of interpreters 17/9

Interpreters as information providers

The interpreters' main concern was not only translating what they hear, but, when necessary providing relevant information to the client and the counsellor with the aim of making the therapeutic relationship effective. When working across languages, it is inevitable that meanings and words will be missed and that words will be added to what is said to enhance the meaning. This becomes particularly problematic when interpreting in the mental health field. The participants agreed that their contribution was important to maintain the triadic relationship, providing clients with additional information about how the system and the organisation worked and informing the counsellors about the clients' cultural background and their understanding of what happened to them. Diane emphasized its benefits for professionals:

‘...I think it’s important because it can only help them to do a better job...I think that any extra knowledge the counsellors can have with reference to the cultures...it can only be a positive thing...’(Diane-407)

Maryam highlighted its necessity for the client:

‘...in some situations, I felt like I did, uhm give more information than I was supposed to. Because you are being told something, you have got to give that across...otherwise, the client won’t be able to understand that...’(Maryam-94)

Pezous (1992) and Dearnly (2000) suggest the use of the Culture Broker mode of interpreting as it allows the negotiation of cultural understandings. Tribe & Morrissey (2004) further mentioned the use of the Psychotherapeutic or Constructionist mode of interpreting, particularly for psychotherapy and counselling as it promotes working on meanings.

Traumatisation of interpreters

This sub-category describes the distress that interpreters experienced. The participants viewed themselves as vulnerable in this complex process. Interpreting for mental health could upset and cause distress, which challenges parties involved at many levels.

Interpreters not only had difficulty in discharging the content of some sessions, but also found that their past own traumas could be reactivated by the clients' input (Doherty, MacIntyre and Wyne, 2010). They therefore explained that they tried to keep the content intact, but they were still subject to transference and counter-transference experiences. They emphasized that they were human beings, hence they were emotionally touched and sometimes unexpectedly shocked by the clients' stories. Ali described how one client's story touched him:

‘...she was talking very few words, and crying, and... [stuttering] with body language, err, she wanted to express herself. So, it was difficult for me... She was telling a story about her husband and her children, and how her husband, you know, errrr, tortured her, she became, err, you know...It was a bit hard for me.’ (Ali-463)

Many researchers reported that emotional distress including intrusive thoughts, depression, anger, nightmares, disdain, paranoid ideas, stress, frustration, irritability, mood and behaviour changes have been reported by interpreters (Butler, 2008; Miller et al., 2005; Valero-Garces, 2005; Fatahi, Mattsson & Skott, 2005; Loutan, Farinelli and Pampallona, 1999).

Interpreters' emotional reactions

This category further reports the common emotional reactions of the interpreters to the process. They argued that the negative emotions that were evoked by many factors exhausted them and these included feeling scared, upset, shocked, angry, and experiencing sleeping disturbances. Participants argued that these emotions were mainly caused by service providers' lack of understanding, their criticism, and by hearing traumatic stories and witnessing scenes. Their responses also suggest that anger and frustration were sometimes caused by interpreters feeling too close to the clients and that they're not being trained adequately.

‘It really, really, sort of, traumatized me ... I went home and cried.’(Julie-49)

Although professional interpreters are trained to remain transparent yet not taint the outcome, those who lack proper training, will inevitably be vulnerable when they cannot

exercise their power. For Ameer, anger was caused by the unfair treatment towards not only clients but also interpreters:

‘...it makes you feel [silence]...it’s not fair.’(Ameer-732)

Being deeply affected by the client stories and the process also suggests, as Sande (1998) stated, being unprepared for their own emotional responses, and lack of experiences and knowledge. Some participants likened the harshness of interpreting, particularly the conduit interpreting when rendering sensitive material, to being a robot and emotionless, which they conversely found inhumane. Hsieh (2004) reported similar findings that her participants stated that they were not robots. Doherty et al. (2010) surveyed 18 interpreters to explore the impact of mental health interpreting on their emotional well-being. They found that 56% of interpreters reported being emotionally affected by the work, that 67% found it difficult to put clients out of their mind post-session, with 28% reporting difficulty in moving onto the next job, and 33% disclosed that interpreting for mental health clients had an impact on their personal lives.

Role conflicts encountered

This main category extends the challenges that the participants encountered. It also shows the most common dilemmas that stressed out the interpreters. They claimed that conduit or mechanic interpreting was not fit for purpose at all times, especially in mental health as it did not allow interpreters to exercise their linguistic power and communicative strategies. Hsieh (2004) drew four sources of conflict out of her research with interpreters. These role conflicts include ‘Others’ communicative practices’, ‘Changes in participant dynamics’, ‘Institutional constraints’ and ‘Unrealistic expectations’ (p. 4).

The participants argued that many frustrating incidents resulted from being pushed into conflicting arenas with service providers and clients. They argued that these dilemmas resulted in confusion with regards to their roles. The responses of this study’ participants yielded three sources of dilemma:

- Clients’ expectations from the interpreters 11/5
- Unexpected disclosures from the clients 11/4
- Unexpected remarks by the service providers 9/3

Clients' expectations from the interpreters

This role conflict resulted from the clients' tendency to expect or ask for more than an interpreter could do. Their extended demands included asking for their letters to be translated and making phone calls on behalf of them to their landlords or the courts, for example, to adjourn their hearings. These tend to take place either before or after the sessions. Clients also expected the interpreter to tell the healthcare practitioners more than the client had already told them, telling their stories either outside or inside the consulting rooms before sessions, expecting the interpreter to summarise everything at once inside. Diane describes this situation as confusing and, also, a natural reaction due to coming from the same culture or country.

‘...there is this confusion; the interpreter has to become some sort of a friend! ...Someone who can speak my language and, maybe, he can help me do something else!’(Diane-167)

The participants agreed that the clients should be educated as to what they should or should not expect. In some cases, the incidents were dealt with by service providers informing the client about the interpreter's role. Another participant added that clients' unwillingness to cooperate could result in the interpreter feeling obliged to do more for the client who otherwise would not cooperate much. Hsieh (2004) adds that refugees and asylum seekers particularly may not be able to act as competent participants due to their cultural understanding and expectations. Maryam pointed out:

‘...some will be saying things like ‘You are my sister.’ [Since] You speak the same language...you have that connection.’(Maryam-41)

Unexpected disclosures from the clients

The interpreters shared the view that clients' stories or comments confused them to the extent that they were unsure as to whether they should interpret them or not. Clients not only made unexpected disclosures about themselves, but also commented on the healthcare services and service providers. This source of role conflict for interpreters is caused by the ways in which other speakers communicate (Hsieh, 2004). Clients may not know how to maintain the communication or the relationship in an expected manner or pace. Hsieh (2004) argued that clients and practitioners may not be confident in maintaining the conversation according to the rules of an aided communication through a third person. This

could be not speaking in private or whispering to the interpreter while in sessions as Ann experienced.

‘...I can’t say to the counsellor that ‘she [the client] didn’t like you’...I am not there to tell who she likes or not... Also, you can’t whisper...’(Ann-263)

Ameer shared her dilemma after the disclosure of a client’s criminal activity:

‘I went to [the name of the hospital]. There was a [the patient’s ethnicity] guy. He was from mafia, burnt his hand... the doctor or nurse was asking him: ...‘Where are you going?’...He said ‘I am going to [the name of the City]...I will go and steal’...I said to him ‘Shall I translate this?’ He said ‘Yes’... The nurse was shocked.’(Ameer-716)

Unexpected remarks from service providers

This role conflict concerned the healthcare staff’s comments either on the interpreter’s performance or the client’s story. Although all the participants acknowledged that their duty was to interpret as accurately as possible, the situation could change unexpectedly when any judgemental remarks were made. Ameer explains how she was perplexed:

‘They [staff] sometimes speak against the clients...They do racism! ...and you cannot translate those.’(Ameer-735)

In Parveen’s case, the service providers disclosed their opinion about a client, ignoring the role of the interpreter:

‘.... ‘He [the client] knows how to speak English, but don’t tell him that!’ And you are looking..., you know, what do I do with that?’(Parveen-728)

Doherty, MacIntyre and Wyne (2010) argue that professionals may not always have a clear understanding of the interpreter’s role. This can put pressure on interpreters to quickly adapt to various work settings or adopt new roles.

Coping strategies

This category reports how the participants dealt with emerging challenging situations. Their coping strategies were in line with the literature that includes setting clear boundaries, accepting their limits (Hsieh, 2004), distracting themselves from the session content, cognitive withdrawal (Holmgren, Sondergaard and Elklit, 2003), talking to a mental health professional, talking to friends or family members, carrying out fewer mental health interpreting jobs, and undertaking further training (Doherty, MacIntyre and Wyne, 2010; p. 40). The participants' responses are clustered in two sub-categories:

- Using own resources 13/5
- Being obliged 11/3

Using own resources

The interpreters stated that they had to find their own ways to overcome their feelings. They found most resources around them such as their families or friends circle by observing confidentiality and anonymity, arguing that they were not given any organizational support towards their emotional swings resulted from working through highly charged sessions. Holmgren, Sondergaard and Elklit (2003) found that interpreters utilized mutual support from each other to cope, but in this study the participants stated the opposite, which calls for an organisational support:

‘Well, it depends on which company I’m working for and which environment I’m going to. There are some agencies and organisations offer that. But some others don’t. So again, fortunately, I’ve been doing it for a long time now, I sort of use some techniques myself just to move on to the next job.’(Diane-195)

Maintaining confidentiality, neutrality and anonymity can be a major concern for interpreters due to not being able to share the session contents with anyone (Tribe, 1998a; Fatahi, Mattsson and Skott, 2005; Doherty, MacIntyre and Wyne, 2010). There is a subtle dynamic that interpreters might come from the same community as clients and other interpreters, which makes it more difficult for them to talk about clients' cases. Maryam used her positive thinking to combat her bewilderment caused by difficult cases:

‘...I make myself realise that there are situations out there like that, and I shouldn’t take it personally, and realise that this may be another experience that I am [not] aware of...’(Maryam-232)

Another way of overcoming one’s feelings was to forget. Holmgren, Sondergaard and Elklit (2003) described this as Detachment or Cognitive Withdrawal. Hsieh (2004) argued that redefining relationships and identities imposes challenges when dealing with inappropriate, unethical and irrelevant comments made. Fatahi, Mattsson and Skott (2005) marked emotional constancy as an important skill for interpreters. This study’s participants explained that they handled their emotions by releasing their anxiety and stress through relaxation; listening to music and hoping for the best for the client.

Being obliged

A common strategy employed by the participants was ‘go with it’, do whatever the situation dictated. This however indicates being unprepared for the unexpected and taking risks, especially when the interpreters lack training. Some participants conformed to what clients asked them to do; although they seemed to make the best decision at the time, their responses implied feelings of helplessness.

‘If he [the client] said so, I have to translate it, if he said: ‘Keep quiet.’
Then you have to keep quiet...’(Ameer-753)

Parveen described her feelings that resulted from obliging other members of the triad and the situations. She described the outcome as somewhat inhumane that suggests loss of individuality and hence control.

‘Personally, with my own experience, I have become a
machine!’(Parveen-328)

Hsieh (2004) highlighted that trained interpreters manage to create boundaries by choosing their role according to where they work. They describe their role to the other speakers, for example, as a conduit interpreter in hospitals or an advocate in other settings to explain their extended roles.

Counsellors' ways of working

This category reports the observation of the interpreters with regard to the counsellors' ways of establishing trust and a working alliance with clients and interpreters. The participants were in consensus over the necessity for an effective and beneficial therapeutic progress and outcome. The participants asserted that since counselling involves vocalizing emotions and feelings, trust was the key. The participants' responses are clustered in two sub-categories:

- Understanding clients fully 11/7
- Working closely with interpreters 9/5

Understanding clients fully

The interpreters observed that the most important element in establishing trust with clients was to work with them without judging. Understanding culture of the client in order to avoid potential resistance to take up of services or collaborating with the providers was also paramount. This effort ranged from grasping the clients' sensitive areas to understanding the difficulties they faced on daily basis. Diane underlined the complexity of this in relation to mental health issues.

‘...that’s what the frustration comes along...especially in mental health environments...vulnerability of the patient is actually much, much, higher than a patient in a different environment...Experiences that the patient went through are very difficult to explain because of the different culture, ...people in certain cultures are not used to talk about their problems.’(Diane-50)

It has been noted that when interpreters and therapists are appropriately tuned in, emotional communication becomes more satisfying (Bhui and Morgan, 2007) and mental health professionals become more reflective in their work (Raval, 1996). Century, Leavey and Payne (2007) suggested counsellors should be curious to learn about their clients, noting that counsellors admired refugee clients' dignity and courage despite being shocked and harrowed by their traumatic. A group of counsellors reported that acceptance, containment, awareness of past and present problems and empathy are the features of good counselling

practice with refugee clients (ibid, 2007). Hansen, Pepitone-Arreola-Rockwell and Greene (2000) described these features as multicultural competencies.

Working closely with interpreters

The attempt to establish trust and a working alliance with clients further revealed itself in counsellors trying to work with the interpreters in more creative ways, sharing more information and experience. They highlighted that re-booking the same interpreter was an important strategy in order, particularly in mental health, to avoid clients having to re-tell their story to different interpreters. This was argued to be beneficial for clients as trust is facilitated by a trusted interpreter.

‘...Maybe the client needs two, three or more sessions... if you call [the interpreter] in for the second session...Do it with the same interpreter.’(Parveen-655)

Any pre-session talk between counsellor and interpreter has also been reported as beneficial. It establishes rapport and enables the interpreter to be informed about the interventions being used. Counsellors can establish trust between themselves and clients by actually facilitating the establishment of the trust between clients and interpreters. The participants argued that one of the ways of achieving this is for interpreters to have a pre-session talk for familiarization only with the client.

‘...walk in half an hour early to see the patient, to have this little conversation for trust [and] for the bond.’(Layla-17)

In most cases, these pre-sessions are not arranged by the service providers or the interpreting agencies. Tribe and Lane (2009) argued that these practices must be part of the positive practice guidelines in working with interpreters. Also, an appropriate usage of interpreters is highly likely to result in a high return rate after assessment, and more importantly, makes clients feel better (Kline, Acosta, Austin and Johnson, 1980).

Theme C: Interpreters’ perception of their work

This theme concerns the nature of interpreting and how it was perceived and defined by the interpreters. It reports their views on what interpreting involves, how interpreting itself changes depending on the context and the modes of interpreting. Theme C consists of three

main categories and eight sub-categories with one hundred and forty-three corresponding units of meaning that are presented in Table 14.

THEME C: Interpreters' perception of their work		
Main Categories	Sub-categories	Number of Meaning Units/Number of participants
Satisfying and challenging	A human and helping relationship	20/8
	A dream job	20/7
	Working through challenges	16/5
	Changes occurring in communication	15/5
Contextual Interpreting	Mental health interpreting	26/7
	Interpreting in other contexts	15/6
Modes of Interpreting	Conduit type	19/7
	Culture broker and advocate	12/4

Table 14: Theme C (Interpreters): 'Interpreters' perception of their work'

Satisfying and challenging

All participants highlighted the humanistic, learning and challenging nature of their job, defining it as a communicative activity through which people identify and meet their needs. They also acknowledged that interpreting was based on individuals' accounts and emotions, and that mental health interpreting was emotional and intimate. Some participants drew attention to the empowering aspect of their job, and some reported the challenging aspects. Four sub-categories were emerged from the responses:

- A human and helping relationship 20/8
- A dream job 19/7
- Working through challenges 16/5
- Changes occurring in communication 15/5

A human and helping relationship

There was consensus among the participants that interpreting was about human relationships and hence about helping people. They mentioned various kinds of help such as emotional help by being there for their fellow countrymen and women whose command of English was either absent or very limited, but the most frequent help mentioned was facilitating the communication between the clients and the service providers.

‘...I see myself as the bridge between two people who without me would not be able to communicate....’(Diane-27)

They compared the nature of their job and mechanical interpreting, where no emotions were allowed, as Ameer stressed below, denying the human side of the interpreter.

‘... It is my duty as a human being...This lady..., she doesn’t speak English at all. She is old, and it was stressful for her daughter, she is 18, young and blind...’(Ameer-240)

Even in medical interpreting, suggestions have been made that interpreters should adopt a ‘cultural mediator’ role (Hudelson, 2005; Weiss and Stuker, 1999; Faust and Drickey, 1986). It is argued that conduit interpreting, where word-for-word translation is required and the interpreter becomes invisible, is not suitable for mental health and many healthcare settings where physicians require further input to enable them to understand patients’ cultures and attitudes towards treatment and medicines (Hsieh, 2001; Valero-Garces, 2005).

The participants believed that interpreting resembles counselling in terms of being based on words, meanings and feelings; therefore, emotions were expected to be interpreted too. The interpreter had to engage through active listening and empathizing with clients, paying attention to details. Gigi summarized the nature of empathy below:

‘...you have to be in their shoes.’(Gigi-358)

A dream job

This sub-category reflects the participants’ overall evaluation of their job. They explained that interpreting offered satisfaction, yet brought challenges when working with different cultures and languages. The participants indicated that their satisfaction resulted from

being a bridge between two persons who otherwise would not be able to communicate effectively, offering their help to their fellow countrymen and women, and sharing their experiences. The participants reported excitement, curiosity and motivation to learn more and improve skills and therefore were pleased when their clients seemed moved, their moods were lifted, when the mental health professionals looked content with the job done, and when they were repeatedly requested by the clients or providers as in the case of Diane below.

‘...it’s always very rewarding when they [interpreting agencies] call and say to me ‘They ask for you.’ That makes it all worthwhile.’(Diane-423)

For Layla, it was more than that:

‘For me, it is like doing my dream job...’ (Layla-39)

This participant, for example, shared that interpreting assignments provided her with opportunities to meet new people, talk to them, and see how they were coping, in short, to socialize. She added that especially in mental health, seeing the client being helped by counsellors or social workers and the service providers being happy about what she offered was a success for her. Although not vocalized explicitly by other participants, it is the assumption that this feature of interpreting jobs with the opportunities for self-growth and personal development is likely to encourage interpreters to stay in the sector.

There is evidence with regard to improved practices and enhanced personal feelings when there is an effective working alliance with interpreters and clients. Doherty, MacIntyre and Wyne (2010) found that the common rewards for interpreters doing their job were the appreciation shown to the interpreter, seeing clients get better with reduced anxiety over time, facilitating communication, developing a relationship with clients, learning about different cultures and mental health treatments, knowing that they provided accurate interpreting, clients’ gratitude, being requested again, and clients’ tendency of further rapport (p. 36). In another study, it was concluded that their satisfaction resulted from the fact that they offer highly-technical, invaluable and emotionally-charged services (Miller et al., 2005).

For Julie, the motivation for her to do this job was pragmatic as it related to necessities within their community. Young members of new refugee communities with language skills felt obliged to become involved.

‘...for me it is not been that I wanted to do it.... It was a need!...I did this job when my family came over....Because your parents do not have anyone to call upon and the services are not offered or nobody speaks the language.’(Julie-116)

Working through challenges

Here a variety of difficulties, hardship and challenges that the interpreters faced are outlined. Some of these experiences reflected the physical aspects of interpreting jobs such as driving long distances or relying on public transport, while some depicted the emotional side of it. The participants argued that working with different types of clients and service providers, and with a limited amount of information, challenged them. The cases mentioned during the interviews included Ameer having to tell a patient that s/he had one month to live due to cancer; Parveen, seeing a patient with 3rd degree burns without his limb, and Ann being smacked by a mental health patient.

Layla highlighted another aspect of interpreting that is witnessing an unacceptable practice. She explained that she confronted one of the healthcare staff at the risk of losing her job when advocating the patient’s right to be treated with respect and dignity.

‘...a doctor was talking to an old lady. She was about 70.... [when] trying to move her, she said: ‘I can’t do that.’...Doctor was shouting at her. I had to tell him off...I couldn’t keep quiet...’(Layla-525)

Julie extended the challenge to working with asylum-seekers and refugees, adding that the sessions became unbearable when traumatic memories resonated with her own experiences, as in the case of Geneva Red Cross interpreters (Loutan, Farinelli and Pampallona, 1999) and Kosovon-Albanian interpreters who had been terrorised and persecuted in the 1980s and 1990s (Holmgren, Sondergaard and Elklit, 2003). It was reported that these interpreters were already traumatized, and therefore did not get as much job satisfaction as interpreters who had not had such experiences. Julie was there:

‘... It really traumatized me, and I was crying...There was a situation where individual had been in the war. I lived through that. It touched something in my past...which I could not sort of help...’(Julie-549)

Changes occurring in communication

This category reports the changes experienced in communication throughout both the interpreting and the therapeutic processes. The participants claimed that interpreting itself was more than a translation of what was said, and this had to be conveyed.

Ameer was concerned about any pauses in the communication when translating emotions.

‘...If that person tries to tell his emotions...stop there and let that translates itself... When you translate, her cry stops, and her emotion has gone!.’(Ameer-648)

Tribe (1998) and Patel (2003) noted that translation itself becomes a barrier when a third person joins. The participants stressed that counselling through a third person took longer than a dyadic encounter would take, and involved conveying not only words but also emotions and non-verbal gestures. Taft (1981) defined interpreters as ‘interlinguistic mediators’ whose role is to interpret the expressions, intentions and perceptions of one group for another to establish a balanced communication, which requires ‘cultural sensibility’ (in Valero-Garces, 2005; p.75).

Contextual Interpreting

This category further illustrates the diverse nature of interpreting which can take various shapes and means following different rules and guidelines, depending on the setting where the interpreting takes place. The participants argued that their experiences varied according to the culture of the organisation they worked for and the staff they worked with. Their responses are clustered in two sub-categories:

- Mental health interpreting 26/7
- Interpreting in other contexts 15/6

Mental health interpreting

Interpreting in the mental health field can be more demanding than interpreting in some other contexts partly due to its emotional nature. The participants stated that they found mental health interpreting hard in terms of understanding clients' mental health conditions and conveying all cultural utterances and emotions. Diane confided that it could be draining and frustrating due to cultural issues:

‘...certain session can be very tiring...because of the recollection of events...’(Diane-115)

Parveen underlined the risky nature of it:

‘...as soon as you leave the building...you don't know who is following you.’(Parveen-870)

Interpreting in other contexts

The other contexts in which the participants interpreted included courts, refugee centres and social services. The participants differentiated between the styles of working and the rules that must be followed in these settings. Parveen explained her experience of a tribunal case where her empathy for the client was not appreciated.

‘...The lady came, walking in with the walking stick. When she was about to sit on the chair... her walking stick fell. Then she fell down ...I tried to grab her! There were the chairperson, the disability carer, the doctor, three or four of them around the tribunal table, and I was told: ‘Miss interpreter! Do your job!’(Parveen-374)

Diane described the delicate nature of a home visit:

‘...it's just a different environment... a more familiar environment for the patient...it's friendlier, sometimes, because the social services people try to be representative and as friendly as possible.... Otherwise people are very worried when they see Social Services staff...’(Diane-296)

Modes of interpreting

This main category summarizes the early dichotomy regarding the role of interpreters. Interpreters' roles have changed greatly as a result of wide-ranging societal developments such as migration and the increased level of accessibility of health and social services. Widespread mobility and wars have caused people to travel in search of a better life. Multicultural societies with economic prosperity are forced to offer more to these newcomers, and this has imposed new challenges. So, the interpreters and translators' roles have been adapted to the domain in which they work. Interpreters will often have relational ties with their communities as they come from close-knit communities. Interpreters' roles have been expanded to being more inclusive and diverse, which the participants touched upon. The interpreting styles they used are presented below.

- Conduit type 19/7
- Culture broker and advocate 12/4

Conduit type

Extended from the neutral interpreter perspective, conduit interpreting acknowledges that message transmission is more than word-for-word translation between languages. Interpreters as conduits are best utilized in conference and diplomatic interpreting which assumes the interpreter is an agent of message transmission. Parveen and Diane explained:

‘Interpreter is only a voice; she [the client] can be saying anything but I was not allowed to add on...’(Parveen-106)

‘...I have to translate everything, and I have to flag out everything even if it's swear words, even if it's in another language that client speaks...’(Diane-161)

The main concern here is the effectiveness; all responsibility is based on the excellent communication skills of the provider, not the interpreter. The interpreter is regarded as a ‘bridge’ (Avery, 2001). The National Council on Interpreting in Healthcare (2001) however argued in their working paper series that although interpreters were mainly responsible for conveying messages in an appropriate way as accurately as possible to both

parties, this still involved more active engagement with the wellbeing of the client and the effectiveness of the process. Given the continuum nature of the process, the interpreters' role varies ranging from being an invisible transmission box to an active agent.

Culture broker and advocate

The neutral interpreter or conduit interpreting mode have their own limitations and specific usages in certain domains such as legal contexts. The triadic therapeutic relationship may not function fully due to its being a highly-mechanized process. Hence it may not be suitable for mental health interpreting where a substantial amount of cultural meanings is exchanged. Therefore, the culture broker interpreter perspective acknowledges interpreters' social presence in their community (Tribe & Morrissey, 2004).

The participants argued that in the culture broker mode of interpreting, interpreters were able to provide the service providers with further knowledge that potentially strengthens what the client has already said or indeed has not said due to a different understanding. Julie shared her experience with a psychiatric nurse:

‘... There are Gypsy travellers from Bosnia and their culture is completely different from English culture. ...the young man was questioned. His dad has taken away his money... He did not have any independence and this was really affecting him and he was very depressed, very isolated...the CPN was saying: ‘... we will find your own house, we will move you there’. And I couldn’t explain to them that there was no use, because his dad controls the whole family. It is their culture; you answer to the father. Even if he leaves it wouldn’t work...After the session ended, and I had to brief them on that culture...’(Julie-413)

The interpreter’s extended role also involves being a ‘referral advocate’ where they can suggest referral of the patient to a certain place or even accompany the patient to the assigned place (Avery, 2001; p. 9). In the advocate mode of interpreting, interpreters could go one step further if it is encouraged by the service provider, giving additional support to the client such as reminding them of their rights of which they might not be aware. Hence, this sometimes entails negotiating with the service provider or requesting further services for the benefit of the client as Ameer explained.

‘...a blind girl with an old lady...and I could not leave [them] like that, because she could’t speak English... [the interpreter asks the receptionist:] ‘Can you change the address?’, ‘Can you prescribe her this medication?’...Now, I am doing this for the daughter, which the receptionist was supposed to be doing...’(Ameer-223)

Some authors regard interpreters as cultural experts or consultants (Tribe 1998a; Drennan & Swartz, 1999; Dubus, 2009) who can provide valuable information to the other parties. The interpreter in these roles is active and involved with the clients’ well-being as a team member who cares not only for the quality of the communication but also the content. In this, the expertise of the interpreter would lie in their linguistic skills and their level of understanding of the ‘interpreter-assisted communication process’ (Avery, 2001; p 8).

Tribe and Morrissey (2004) argued that this mode worked best within mental health and psychological well-being.

Summary of the interpreters' data

The interpreters revealed that interpreting in general, and mental health in particular, was far from the level it should have been. They underlined widespread inconsistencies in service provision, and the lack of understanding and recognition in the staff. They elaborated on how they perceived mental health and mental health professionals, and how they found themselves in conflicts between client needs and practitioner interventions.

The interpreters acknowledged common factors that hindered and intervened in establishing trust and alliance. These include clients' presenting issues such as physical illnesses, varying needs, mental health illnesses and official statuses such as being an asylum seeker. They further elaborated that conduit interpreting itself imposed hardship on all involved, especially when interpreting for mental health cases, recognizing the mismatching nature of the languages in terms of the content and durations of the conversations, which left the counsellor as well as the clients uneasy. They argued that the attitudes of the staff to the interpreters and the clients not only did not help alleviate the non-English speaking clients' multi-faceted emotional difficulties but also put the interpreter in a position of role conflict.

These became problematic incidents as the interpreters were unable to handle complex psychological matters: they were working through two languages and cultures and both sides were expecting more than what an interpreter could provide with such little background information about the clients. They also lacked information about how different mental health practitioners operate, and about common mental health problems.

They concluded that they needed support in terms of training, supervision, and briefing and debriefing. The results show that the interpreters mostly used their own ways of helping themselves in coping with the emotional strains that emerged.

Overall, the interpreters were satisfied with their job: they enjoyed helping people, bridging clients' needs and professionals' support, alleviating client distress, and learning along the way.

CHAPTER 5: FINDINGS FROM THE COUNSELLORS' DATA

This chapter details the outcomes of analyses of the data from the focus group and the in-depth interview group with the counsellors. First, the socio-demographic information of the counsellors and the statistical findings will be given. The themes and the categories will be reported in a systematic way with the quotes from the participants.

This section will end with a summary of the findings.

Socio-demographic characteristics of the counsellors

These details are given in Table 15. In total, ten counsellors took part, of which five were from the focus group and five from the interview group.

The participants in the counsellors group included therapists, counsellors, mental health workers and psychologists. Since at the time of the conversations, all were offering therapies mainly in the form of counselling, the term 'counsellors' will be used throughout the text.

The average age of the counsellors in both groups is 44.8. The average time of being in this work is 7.5 years. The average stay in the UK was 45.8 for the interview group only.

Four occupied both counselling and management positions and three were offering counselling. Three of them were Europeans, three were Africans, and one was Asian. Seven stated that they were bilingual/ bicultural, one stated he was not. Seven stated that they did not receive any training towards working with ethnically different clients, one said he did not. Seven stated that they received supervision, one marked it as N/A (Not Applicable).

Socio-demographic variables	Pseudonyms of the counsellors: Focus group					Socio-demographic variables	Pseudonyms of the counsellors: In-depth interview group				
	Yan	Ali	Yigido	Flora	Ruby		Jane ³⁰ (Flora)	Maria	Rosie	Sonia	Zishan ²⁶ (Ali)
Gender	<i>Male</i>	<i>Male</i>	<i>Male</i>	<i>Female</i>	<i>Female</i>	Gender	<i>Female</i>	<i>Female</i>	<i>Female</i>	<i>Female</i>	<i>Male</i>
Age	53	40	45	48	25	Age	45	53	42	54	41
Education	<i>BSc. Psycho MSc. In Counselling Psychology</i>	<i>Foundation degree. Counselling</i>	<i>Mechanic</i>	<i>Diploma. Counselling</i>	<i>BSc. Psycho. MSc Forensic Psychology</i>	Education	<i>Diploma</i>	<i>BA & Postgrad. Diploma in Psychodrama</i>	<i>Diploma. Integrative Counselling</i>	<i>Degree. Psychotherapy</i>	<i>Diploma. Counselling</i>
Current occupation	<i>Director /Counsellor</i>	<i>Well-being practitioner</i>	<i>Gardener/ support worker</i>	<i>Counsellor</i>	<i>Managing Director</i>	Current occupation	<i>Counsellor</i>	<i>Clinical Director & CEO of a counselling organisation</i>	<i>Counsellor</i>	<i>Clinical director</i>	<i>PWP. Intensity worker. NHS</i>
Duration of work (years)	20	2	4	4	4	Length of time doing this job	10	11	3	6	2
Ethnic background	<i>Jewish/ British</i>	<i>Bangladeshi</i>	<i>Black African/ Eritrean</i>	<i>Caribbean</i>	<i>Bosnian</i>	Ethnic background	<i>Afro- Caribbean</i>	<i>White European/ Jewish</i>	<i>Pakistani</i>	<i>Afro-Caribbean</i>	<i>Bangladeshi</i>
Bilingual or Bicultural	<i>Bicultural</i>	<i>Yes to both</i>	<i>Yes to both</i>	<i>No</i>	<i>Yes to both</i>	Languages spoken other than English	<i>No</i>	<i>Spanish</i>	<i>Urdu/ Punjabi</i>	<i>Caribbean Patia</i>	<i>Bangladesh, Urdu, Hindi</i>

³⁰ These participants attended both focus group and interview sessions.

Training towards working with ethnically diverse clients	<i>Variety of courses</i>	<i>Trainings in Level 2 and 3</i>	<i>Counselling, horticultural therapy</i>	<i>Yes</i>	<i>Yes, through the organisation</i>	Any training for working with interpreters	<i>Yes</i>	<i>Yes.</i>	<i>Integrative Counselling</i>	<i>yes</i>	<i>No</i>
Any supervision received	<i>Yes. Monthly. External</i>	<i>Yes.</i>	<i>Yes</i>	<i>Yes</i>	<i>No</i>	Supervision received	<i>Monthly</i>	<i>Monthly</i>	<i>Monthly</i>	<i>NA</i>	<i>Forth-nightly</i>
						Length of stay in the UK (years)	<i>45</i>	<i>53</i>	<i>42</i>	<i>54</i>	<i>35</i>

Table 15: Counsellors' socio-demographic characteristics (Focus and Interview groups)

Findings of the Thematic Analysis

This section reports the findings of the thematic analyses employed of the data collected from the focus group and interview group counsellors. The data yielded three themes, twelve main categories, thirty-seven sub-categories and five sub sub-categories with six hundred and forty-nine corresponding meaning units in total. The themes are titled ‘Dynamics of the triadic therapeutic relationship’, ‘Vicissitudes of therapy and interpreting fields’, and ‘Good practice issues and recommendations’. These themes and all the categories are presented in Table 16.

Theme A: Dynamics of the triadic therapeutic relationship

This theme concerns the underlying dynamics of the three-way relationship in therapeutic settings, and how the counsellors worked towards the best outcome for all members of the triad. The counsellors’ responses reveal that the whole process of offering emotional help through a third person was challenging, complex, yet educative, pushing the limits of the services and skills of the counsellors and interpreters. Theme A consists of three main categories, ten sub-categories and five further sub-categories with two-hundred and fifty-three corresponding meaning units.

THEME A: Dynamics of the triadic therapeutic relationship			
Main Categories	Sub-Categories	Sub sub-categories	Number of Meaning Units/ Number of Participants
Counsellors' ways of practicing	Establishing trust and alliance with clients	<i>Engaging with clients further</i>	19/7
		<i>Contracting and assigning clients</i>	13/6
		<i>Allowing enough time</i>	9/5
	Handling power relations	<i>Setting up the scene and the goals</i>	16/5
		<i>Using a second therapist</i>	14/2
	Regarding counselling as a learning process		28/10
	Further engagement with interpreters		22/6
An emotional and blind process	Working with sensitive issues and unknowns		28/10
	Working with cultures, meanings and translations		24/6
	A broken rhythm		17/8
Clients' characteristics	Anxious about confidentiality		23/8
	Unaware of the process		22/9
	Dealing with multiple illnesses and issues		18/6

Table 16: Theme A (Counsellors): 'Dynamics of the triadic therapeutic relationship'

Counsellors' ways of practising

This main category covers the ways in which the counsellors practised. Their responses were pertinent to how they established trust and alliance with their clients and interpreters alike, and how they maintained balance and control throughout the whole process. Their responses are clustered in three sub-categories:

- Establishing trust and alliance with clients 41/8
- Handling power relations 30/5
- Regarding counselling as a learning process 28/10
- Further engagement with interpreters 22/6

Establishing trust and alliance with clients

The counsellors argued that trust and alliance were the milestones on the route to a satisfactory therapeutic relationship. They tried hard to achieve it through well-thought-out engagement practices such as sensitive approaches to clients, reassuring and informing them with relevant information, and more importantly working through and towards their needs. Below sub-categories show the ways and methods that they had used:

- Engaging with clients further 19/7
- Contracting and assigning clients 13/6
- Allowing enough time 9/5

Engaging with clients further

The counsellors emphasized that long-lasting trust could only be established by understanding clients' mental maps and cultural background through the exploration of meaningful constructs by attending to what they did not say as well as what they said. They argued that understanding and engaging with clients may take different forms and routes; for example, Sonia flagged up the necessity for picking up the unconscious by digging down into the client's story to reach the root of the problem, arguing that as soon as the clients felt heard, the healing process started:

‘...when I asked them what brought them here...their unconscious will pick up all the stories.... I remember a woman telling me, she got expelled from nursery. How does one get expelled!?... I have fundamental belief that people have capacity than the reason why they don’t succeed is to do with things that are going on within them, that blocks them.’(Sonia-156)

While Sonia preferred to go back to the root of her client’s difficulty, Rosie preferred to stay where her client preferred to be.

‘... If the patient need to stay in that marriage or in that situation, then my role is to really facilitate that, and give them as much as I can in therapy...’(Rosie-165)

Therapeutic empathy as part of effective engagement can be embodied in various ways. These depend on the therapist’s flexibility as well as the community or clients’ knowledge (Watson, 2002). Pugh and Vetere (2009) described it as ‘the ability to perceive and understand what a client is thinking, feeling and experiencing within a specific moment’ (p.306).

Contracting and assigning clients

The participants asserted that a good working alliance can be established by attending the identified needs and then offering tailored support by simply assigning them. For a working therapeutic relationship, the counsellors argued that delivering services effectively is equally of paramount importance. The clients should be informed about the procedures, the culture of the organisation, and interventions to be used so that clients will be familiar with the counsellor and activities in due course. As Jane explains, this process involves negotiations:

‘...before we start, we contract into a way of working and the way I am going to get them their goal...So we were working to agree a goal...I would be clear about my style, that I work integrative way, use models that may suit at the time...’ (Jane-106)

Allowing enough time

The counsellors acknowledged that a three-way relationship takes a longer time to establish and settle, and hence clients need more time to understand how things work and to trust the process. Allowing this was argued to be a good strategy for clients to become familiar with the process and other members of the triad.

‘...I will let that go for a couple of sessions to be begin with until they are able to check out with me how much they can trust me. Because it is no good saying to somebody...‘You can trust me’...They need few sessions...’(Maria-261)

When working with people from different cultures, it is important for them know what they are expected to do in terms of thinking and behaving. Practitioners should be aware of the time required for learning and adapting. D’Ardenne and Mahtani (1999), for example, noted the potential cultural differences in understanding and managing timekeeping practices across the cultures, arguing that clients should be informed about the meaning of timekeeping in the host culture.

Handling power relations

This sub-category concerns the management style of the therapeutic encounters, the ways in which the counsellors handled the sessions, and the strategies that they employed in dealing with the dynamics such as transference and power issues. Some counsellors emphasized the importance of counsellors holding the power throughout. Their responses revealed two commonly used strategies:

- Setting up the scene and the goals 16/5
- Using a second therapist 14/2

Setting up the scene and the goals

Counsellors agreed that they should make sure which arrangements they will be working within and what their main aims would be from the beginning. This involves not only deciding which roles and rules to follow but also monitoring other usually unspecified details such as seating arrangements. Some participants were particularly adamant in

making clear who should have the control and responsibility in decision-making and monitoring the well-being of all involved. Although she was assured that the interpreters' role was only interpreting, Maria wanted to ensure that the rest would be handled by the counsellor only:

‘...the clinical judgment has to come from me not from the interpreter...because my job as a clinician is to get essence of something is not quite right. I need to find out what it is and it maybe that it actually the client is not understanding whole thing...’(Maria-215)

It is argued that handling three-way relationships requires diverse and inclusive approaches and interventions, especially when working cross-culturally (Lago and Thompson, 1996). Miklavcic and LeBlanc (2014) underlined the use and the need of culture brokers in clinical encounters across the world, concluding that interpreters acting as culture brokers should be active but not to the extent that they would take over the clinical encounter. They warn that clinicians, therefore, should be aware of this overriding role and its potential harm to the working alliance.

Also, there is evidence in the literature that the presence of an interpreter increases the susceptibility of the mental health professional to lose control and that there is the possibility of the interpreter taking the most credit (Pugh and Vetere, 2009; Miller et al, 2005; Century et al. 2007).

Using a second therapist

This further sub-category illustrates another way of maintaining a balanced therapeutic process, taking into account the well-being of the interpreter. Some counsellors underlined the subtlety of the power dynamics that are ingrained in the institutions in which interpreters can become invisible and hence their needs may be ignored. A balance was needed and it was achieved by prioritizing the needs of clients or empowering interpreters. Although employed in the past, Sonia acknowledged that not all interpreters had the necessary skills to cope with sensitive issues, and, therefore they needed therapeutic protection as much as counsellors did:

‘... there was a woman...blinded by her husband...my heart went
‘OHGHHF!...I know that would affect me. So, once we say we have
an interpreter, we could ask somebody else to bring, mainly to
observe and support the interpreter... We knew that the questions we
were gonna ask and responses that she’s gonna have were going to be
painful...you need to make sure it happens with you, not with the
interpreter. ‘(Sonia-308)

This view regarded triadic therapeutic relationship with non-English speaking clients through interpreters as unbalanced. In an attempt to minimize it, they tried to create a feeling that the interpreter was not invisible through another therapist who was called a ‘Projectionist’ and who watched the interpreter’s well-being. This practice however has been replaced by various other practices such as working with paraprofessionals, who hold qualifications from both the fields of mental health and interpreting, to mentor and contribute to the job done (Dubus, 2009).

Regarding counselling as a learning process

This category concerns how the counsellors perceived their job and made sense of their experiences. They described their job as having a whole conversation with clients and a practice of reflecting. To them counselling was a form of talking therapy in which languages, utterances, meaning maps and behavioural codes are utilized in a structured way. Some felt that their work was purely practical work while others experienced it as a conversation; Flora argued that her work was more of a practice of reflection on what the client meant and wanted to achieve.

‘...counselling is about reflecting...reflecting back feelings,
reflecting back sort of crucial things that could be missed.’(Flora-316)

Sonia underlined the challenging aspect of therapy such as being emotionally drained, having ongoing negotiations of what was said and understood, and sometimes not agreeing with clients at all:

‘...therapy isn’t always...about being empathic, caring and
understanding but, actually, it is also being challenging and
confronting...’ (Sonia-39)

Working with interpreters can offer a more empathic understanding (Pugh & Vetere, 2009); when interpreters provide key information about clients' sensitive issues or cultural behaviours and meanings (Raval and Smith, 2003), new doors to further insights are opened. This reciprocal co-operative nature of counselling as Watson (2011) noted, leads to both learning from the other two, and empowering them. Stevens and Holland (2008) reported the feelings of 'sameness' alongside the 'otherness' in therapists (p.23). Mirdal et al., (2011) found the triadic relationship to be the most helpful aspect of the process, and that the process was quite educative for all members of the triad.

Further engagement with interpreters

Another way of establishing a trustworthy relationship was to closely work with the interpreters. Alliance helped the counsellors to monitor what was happening to both clients and interpreters, to verify potential frustration and allow for the transference of feelings. Some counsellors emphasized the significance of developing emotional and intellectual engagement with interpreters for mutual understanding so that their involvement could be more effective and beneficial. Some therefore suggested treating interpreters as team members, working towards the same aim.

Jane, for example, allied with the interpreters, letting them take notes and reflect on them later with the help of counsellor. Sonia similarly invested her time by having an informal chat with the interpreter, drinking a cup of coffee before the sessions, and getting relevant information about the interpreter and the client. Yan nevertheless highlighted the impact of an adverse scenario:

'...He [the name of the counsellor], could not achieve that alliance because he had an interpreter whom he could not work with...We should do everything to reduce any kind of risk that causes alliance not working.' (Yan-678)

Although most counsellors agreed that interpreters should be part of the team, not all agreed on how to share the responsibility. Dubus (2009) suggested the Team Approach Model in psychotherapeutic work with refugee populations. She shared her experiences of working with Cambodian refugees of Khmer Rouge. In this model, interpreters did much of the therapeutic work and became the main agent in establishing trust and alliance. Counsellors also argued that engaging with interpreters effectively requires obtaining information about

them such as the interpreters' motivation towards the work in order to maximize the best outcome. Sonia was adamant that this was the first step to becoming involved with them:

‘Why were they interpreter?... If it was an active choice, then they would have a different perspective on it than if it just ‘I speak English...so I do it!’...But saying ‘I actually have an interest in people, I am interested in caring profession and supporting people...’ is different.... I would then work with them.’(Sonia-76)

Other counsellors offered similar solutions in their pursuit of learning about the interpreter: for instance, seeing their CVs beforehand or arranging pre-session talks. There is no substantial research evidence on this; however, many authors have noted that interpreters' mind-sets, and hence their work motivation and performance, are largely affected by their adopted working style and the context in which they are working (Avery, 2001; Hsieh, 2004; Davidson, 2000).

An emotional and blind process

This category highlights the complex and challenging nature of the counsellors' work. The entire process seemed to be highly emotional for all involved. The dynamics of the process were evoked by working with clients from multi-cultural and multi-racial backgrounds with and within sensitive subjects. The impact of working with and through languages and interpreters was further highlighted. Participants' responses in relation to the nature of the job yielded three sub-categories:

- Working with sensitive issues and unknowns 28/10
- Working with cultures, meanings and translations 24/6
- A broken rhythm 17/8

Working with sensitive issues and unknowns

Here, some of the challenging and traumatic cases that the counsellors had to deal with are depicted. These cases include war-related tortures, traumas, homosexuality, marital and ritual practices, and domestic violence which sparked strong feelings of shame in clients, their families and consequently in communities. Yan added that asylum seekers in

particular required further emotional support as they tend to come from unstable backgrounds with horrific experiences:

‘...it is highly likely that they come from war zone...that they stay in something horrible or with spirit something like that. It is...70% possibility that there are women, they have been raped. It is very likely that child could have been abused...’(Yan-350)

The counsellors also argued that the characteristics of the clients made the relationship a blind process as the counsellor did not know anything about the client and the interpreter. Sonia felt that it was like working with many unknowns:

‘... you deal with sense of isolation, abandonment, unknown world, it’s like working with disability...’(Sonia-207)

The participants shared that they were lacking not only in understanding clients’ language and their cultural background, but also in knowing what the interpreters could bring into the sessions. Yan explained one of the surprises in which the counsellor had no idea about a particular cultural practice, while the interpreter had been fully aware of it:

‘...a good one is circumcision! So, you could have the interpreter and client being very normal about female circumcision whereas the counsellor was actually being very shocked by the realities of it...’(Yan-417)

The literature suggests that interpreters may normalize somewhat different and potentially unacceptable thoughts and practices for the therapist, particularly when a psychiatric symptomatology is involved. It is argued that this can be a result of an emotional response of protecting the client (Lee, 1997) or that the interpreter is being poorly trained or not trained at all. Stevens and Holland (2008) reported that therapists felt self-doubt as a result of working with unknowns.

Working with cultures, meanings and translations

Drawing on the diverse and complex nature of the counselling work, this sub-category refines the challenge. The counsellors argued that when service providers did not know the language and the dialect or cultural propensities of clients, they felt alien and hence less empathic towards them. Some participants recognized the impact of cultural attitudes and

practices on people when a change was required. The participants' responses revealed distinctive cultural expressions of clients from different parts of the world when conveying their emotions and thoughts.

'...if you are working with [the name of the ethnic background of the clients] ...they shout about and, you think, they are actually gonna punch your nose but in fact they don't. They're expressing themselves...very animating! So, you can often misunderstand the body language and the knowledge of that culture.'(Yan-131)

Some counsellors seemed to be amazed by the ways in which languages affected the process. They reported their frustration of missing some of the meanings and verbal and non-verbal clues due to working through translation.

'...Even though I did all the appropriate body language, nodding my head, maintaining eye contact with patient and observing body language...I didn't know if the interpreter was interpreting what I was saying....'(Rosie-105)

Communicating between different languages is a linguistically and emotionally complex process (Tribe and Morrissey, 2004). Working through translation with the aid of an interpreter may prevent conveying the right empathic message to the clients as interpreters may unintentionally slant the message (Pugh and Vetere, 2009). Linguists suggest that socialization or acculturation have profound impacts on peoples' learning and perception of their new culture. Pavlenko (2008) and Wierzbicka (2004) argue that understanding of a culture and a language in a new country can only be acquired through secondary affective socialization. Some concepts may not be found in their mother tongue. Pavlenko (2005, 2008) notes that a conceptual shift takes place when encountering a foreign language, hence interpretation of emotions tends to change. Therefore, as Ozanska-Ponikwia (2013) and Dewaele & Costa (2013) argue, multilingual people are likely to express themselves in different ways than monolinguals.

A broken rhythm

The counsellors further explicated that working with clients whose English is limited was stressful, tiring, and required more time, more effort and further skills. Some asserted that triadic relationships can violate the privacy of clients who resist progress and hence change.

The counsellors' responses highlight various communicative losses because of the disrupted flow of the communication. Some reported discomfort regarding the conversations that took place between the client and the interpreter, which broke the continuity of the communication and the relationship. Yan explains:

'...When you have the third person, you break the rhythm...You have a moment where you go 'arrh!!! that's what is about!' and then the client recognizes that...It is very difficult to do that with another person unless you are having a joint eureka moment with that individual...'(Yan-90)

The literature shows that triadic encounters can lessen therapeutic empathy, and that 'relational dynamics' become more complex (Pugh and Vetere, 2009). It can be experienced as a 'loss of access to emotional experience' (Stevens and Holland, 2008; p.19). Research on language switching shows that people feel more real, more logical and more serious in their first language than in languages learned later (LXs) particularly when they become emotional (Dewaele, 2010; Pavlenko, 2005; Dewaele and Nakano, 2013). Wilson (2008) further argues that LXs could also be used by people to hide their shyness.

Clients' characteristics

This category concerns the client-related dynamics in terms of what their main worries were, and how they presented themselves and responded to events, people and the process. It is important to understand within which mental and emotional construct the clients think, feel and behave as they bring not only their personal background but also their whole culture with themselves. The counsellors' responses indicated four characteristics of their clients.

- Anxious about confidentiality 23/8
- Unaware of the process 22/9
- Dealing with multiple illnesses and issues 18/6

Anxious about confidentiality

The counsellors asserted that trust was the key issue for clients as they tend to be afraid of authorities. This made them apprehensive towards the service providers and worried about

confidentiality as to what to share with the interpreter and the service provider. The participants reported that apprehensive clients reacted to the interpreters' presence and counsellors' position by checking their professional details.

'...in some countries, every other person is [silence]...They are frightened...I had to have someone interpreting for Farsi...And for the first ten minutes of any engagement with Iranians, they quiz you solidly about the person who is interpreting for you.'(Yan-180)

Dubus (2009) stressed that in the aftermath of conflicts around the world, mental health professionals would be in demand to work and treat at-risk groups. Effective treatments and satisfactory outcomes can only be achieved by adopting culturally appropriate and clinically sound perspectives and interventions (ibid, 2009). Also, as Birkett (2006) noted, system-related issues may contribute further anxiety, reducing trust in clients due to being exposed to a variety of clinicians and settings through cross-referring.

Unaware of the process

Although clients were not expected to know all the necessary information, the counsellors acknowledged that some clients lack even basic skills such as reading and writing not only in the language of the host country but also in their own language. Thus, they were unable to learn enough about the health system and talking therapies. Zishan suggested that the referring source, such as a general practitioner, should inform the clients about what to expect:

'Some of them don't know what's going on...and half of them walk out because they don't know what it entails....'(Zishan-300)

Clients tended to keep the information to themselves, not disclosing it, to decline the services offered, show no response to the standard interventions, and stay silent when they were anxious, unsure or unhappy. Zishan described this as 'having a smoke screen', which prevents counsellors getting to the root of the issues. Mirdal et al. (2011) similarly reported a lack of motivation in clients that exposed itself as a hindering factor in the process. Watson (2011) suggested training to include the ways in which counsellors should actively educate or induct clients into therapeutic methods and cultural issues.

Dealing with multiple illnesses and issues

The counsellors' responses show that they observed their clients not only suffering from mental health difficulties but also health and social problems including losing accommodation and loved ones, separating from the family and lacking in money. These were perceived as making any encounter and intervention more complex and difficult:

‘...changes were very slow because there was a lot of medical problems...So, there was not just emotional, psychological issue, there was the medical problem....’(Jane-77)

The participants concluded that shattered lives had a significant impact on clients' attendance, motivation for change, willingness to take up the services and to adapt to the new culture. Imberti (2008) notes the very nature of asylum seekers particularly, those whose immigration status is ambiguous or undocumented, arguing that they suffer from a chronic state of hyper vigilance that can be powerfully debilitating. The PAFRAS report (2011) also underlined similar factors that can impede people's ability to learn English.

Theme B: Vicissitudes of therapy and interpreting fields

This theme concerns field-related issues in which the counsellors and interpreters operated and experienced the organisational and societal impact of their fields. The impact of the organisational and managerial challenges and expectations are outlined in the light of the counsellors' responses. Wider perspectives on cultural dynamics from the historical and political perspectives are also depicted. Finally, recommendations and solutions that were developed in relation to the ways of dealing with the aforementioned difficulties in terms of organisational competencies are given.

Theme B consists of five main, fifteen sub-categories and one hundred and ninety-four corresponding meaning units. These are presented in Table 17.

THEME B: Vicissitudes of therapy and interpreting fields		
Main Categories	Sub-Categories	Number of Meaning Units/ Number of Participants
The third dimension: Interpreters	A facilitator or an obstacle?	17/5
	Interpreters being traumatized	13/4
	Interpreters' effect on counsellors	12/7
	Interpreters' effect on clients	7/5
Lost in translation	Mismatching translation	14/7
	Untranslatable concepts	13/6
	Interpreters' slants	10/5
	'I can feel it!'	10/5
Organizational competence	Interpreters' accountability	16/5
	Working within intercultural models	15/6
	Working with communities	7/4
Jack of all trades!	Use of untrained interpreters	19/6
	Working through organizational constraints	17/4
The impact of historical events	Don't remind me of the past!	15/1
	Attitudes to be changed	9/4

Table 17: Theme B (Counsellors): 'Vicissitudes of therapy and interpreting fields'

The third dimension: Interpreters

This main category draws attention to the dynamics of the triadic relationship and describes how interpreters influence and are influenced by the processes from the counsellors' point of view. The counsellors acknowledged that interpreters can give rise to both positive and negative emotions and attitudes depending on the context and circumstances. Their presence can on the one hand trigger deep political and historical debates; their absence on the other hand can stimulate the advocacy for basic human rights on behalf of clients.

Participant responses suggest four sub-categories that illustrate the impact of the interpreters:

- A facilitator or an obstacle? 17/5
- Interpreters being traumatized 13/4
- Interpreters' effect on counsellors 12/7
- Interpreters' effect on clients 7/5

A facilitator or an obstacle?

There is no doubt that communicating via an interpreter has an inevitable impact. The data suggests that counsellors viewed interpreters in two ways. Some regarded them as gatekeepers for clients to access the services, and for counsellors to do their job. Maria exemplifies this view:

‘...the interpreter and the therapist together are like a kind of parental dyad. You got two parents there as opposed to one. So, particularly for the people [who] were traumatized, it is very safe to have two people...’(Maria-135)

Using interpreters not only helped improving the accessibility of talking therapies for Black and Minority Ethnic clients, but also assisted in developing better working alliances with them (Raval, 1996; Costa, 2011).

Some counsellors such as Zishan manifested the challenging aspects of their work:

‘...I seem to find it at time quite frustrating because there seems to be a barrier, especially when there is an interpreter...because we cannot get that connection.’(Zishan-11)

Sonia extended the concept of the gatekeeping function to include examining the historical and political roots lay, arguing that the presence of interpreters may be seen as an obstacle for something else such as imposing subtle challenges to the established system. She elaborated on why providing interpreters for asylum seekers and refugees stimulated tension in some institutions particularly those that are not as fully inclusive and caring as they claim.

‘...when we don’t learn English, when we don’t comply with others, they then are faced with ‘Oh my god! We are going to have/ make special allowance for...who don’t speak English! So, there is always, uhm, resistance, as much as is wanted...to providing that because...it makes them feel...‘not good enough.’(Sonia-455).

Interpreters being traumatized

This sub-category underlines the vulnerability of the interpreters from the counsellors’ point of view. Participants reported the interpreters’ ordeal of dealing with clients sensitively with only limited support and training. They observed the interpreters as anxious, in a state of suspension, confused and fearful when complex issues emerged. Jane explained that she addressed the difficulty of a session by debriefing to the interpreter.

‘...You know, the sort of slaughter of a family!... Being in a room with somebody who has experienced that...and interpreter is coming out a very naïve about being warn-torn and tortures and war-torn environments...’(Jane-286)

The literature shows that the emotional content of interpreting of the graphic description of torture or rape could traumatize interpreters and practitioners (Fox, 2001). In one study, the language of counsellors working with refugees was found to be rather ‘weary and defeated’ (Century et al., 2007; p. 34).

Interpreters’ effect on counsellors

There will be many internal and external factors affecting each member’s feelings, thoughts and hence actions. When therapeutic empathy is involved, understanding a client’s mental and emotional experiences of a specific moment is of paramount importance. It may not always be the case that mental health professionals tune in with clients and interpreters. The counsellors argued that they were influenced by the interpreters’ involvement in mainly two ways; feeling either competent or confused, depending on the relationship they established. They felt satisfied, content and confident when interpreters fully informed them about the clients.

‘...I felt quite competent when I [was] coming to the room with her that she will feedback to me...with correct information.’(Flora-47)

There were times when they felt upset and lost upon hearing horrifying stories of the clients, and also confused and anxious about the interpreter-related matters.

‘I felt very frustrated...there was no engagement between me and the patient...’(Rosie-105)

In one research project, clinicians reported discomfort over missing therapeutic content in the translation provided (Pugh and Vetere, 2009). Century et al. (2007, p.36) described it as ‘erosion of confidence’, acknowledging the fragility of counsellor-client boundaries easily being threatened by the broken communication.

Interpreters’ effect on clients

Counsellors observed interpreters having an impact on the clients’ feelings as well. They explained that positive feelings in clients were mainly evoked by the interpreters’ interventions of trying to put the clients at ease. These included engaging with them quickly, explaining matters adequately, making them understand how the system and counsellors work, what the interventions involved and how things were to proceed. Flora reflected on how the clients were opened up throughout the process:

‘...as long as the relationship and alliance have been built between the interpreter and the client, then client feel safe, communicating their own language, umm, and talk about their issues. Then there will be more in-depth conversation.’(Flora-708)

Participants added that negative feelings observed in the clients were caused mainly by a poorly matched client and interpreter dyad, or even triad if it included a mental health professional, by unclear and inadequate translation and lack of empathy. Jane reported their bewilderment when they observed tension between the client and the interpreter who came from the same background:

‘At the start, the client was not happy, because the interpreter was from the same culture and had very high feeling; fear of judgements from the interpreter...’ (Jane-155).

Farsimadan, Khan and Draghi-Lorenz (2011) noted the importance of ethnic matching between the clients and mental health professionals, and of practitioners being attuned to the client’s frame of reference. They concluded that mental health services needed to be

more inclusive and that training clinicians for working with BME clients might not be enough unless ethnic matching was arranged well without compulsion.

Lost in translation

Language and translation issues were manifested as both facilitating and limiting constructs. These issues include the difficulties in the translation of the culture specific concepts, overwhelming ambiguity between what was said and what was interpreted, the interpreters' potential influence or slant in interpretation, and how the participants found out the inconsistencies. The responses are presented in four sub-categories below:

- Mismatching translations 14/7
- Untranslatable concepts 13/6
- Interpreters' slants 10/5
- 'I can feel it!' 10/5

Mismatching translations

This sub-category refers to mismatches and gaps which occurred between the translations provided by the interpreter and what was said by the service provider. Participants reported that they did not get similar or expected reactions from the clients on several occasions where they could tell what the clients would say. Although the participants agreed that one language might not match the other language when expressing culture-bound opinions and emotions, a concise summary given by the interpreter of a long talk by the counsellor was not welcomed.

'...there is so much more going on when the interpreter is speaking to the client...And when they come back to you, it is just two words...and you [are] like 'Where [does] that come from?''(Ruby-103)

Untranslatable concepts

The counsellors acknowledged that the language of therapy and counselling might sound unfamiliar and might be unsympathetic to some clients as these concepts were developed purely with and within the western thinking patterns. It is therefore imperative for

interpreters to grasp the meaning of some cultural concepts like anxiety and other metaphors both in the target and the source languages adequately enough to inform both the client and the counsellor. Yan explains:

‘...it is the metaphor-that is what you are looking at, if you are dealing with different languages, you get none of that. You [have] got to rely on the interpreter to be able to tell you the metaphor...Unless they understand that you won’t be able to do that...(Yan-119)

This extract illustrates that counsellors sometimes work with and through metaphors that may not be easily understood by the client or the interpreter. As Marshall (2004) noted, many eastern cultures are based on collectivist ideology in which concepts and metaphors like individuality, self- fulfilment, and control of one’s life or aspiring for personal space, may not exist or may not be exercised as seen in the West.

Acquisition of sociolinguistic and socio-cultural factors are argued to both broaden knowledge of cultural and social norms present in society, and enlarge the emotional repertoire of its users. It is also argued that foreign language learners internalize concepts that are non-existent in their mother-tongue only through an emotional socialization (Pavlenko, 2008).

It was also reported that interpreters found it challenging to come up with equivalent words for some cultural and value laden terms. This was caused by different constructs within the languages and mismatches in the content and duration of the conversations (Engstrom, Roth and Hollis, 2010). It is natural that inaccurate translation between languages is inevitable. Wierzbicka (2004) therefore suggests that cultural and emotional mismatch can be overcome by contacting with later learned culture (p.97).

Another explanation for the interpreters’ mismatching interpretation and, sometimes, slants, can be because multilingual individuals are able to express themselves concepts through different ways and terms. Dewaele (2016) argues that this is a result of their linguistic awareness and cognitions. Pavlenko (2005) and Dewaele (2013) argue that multilingualism has an impact on identity, transference and projections, emotional expression, early memories and relationships in therapy and counselling. People can feel different, behave differently and express themselves differently in their different languages.

Interpreters' slants

Although interpreters try their best to convey the most accurate meaning for counsellors and clients, it would still be challenging to achieve this concisely. Therefore, interpreters tend to provide further explanation, which may cause further concerns in some counsellors in terms of the interpreters' rendering of the translation. Participants argued that they were most annoyed by the time gap existing between the utterances made and the translation provided, describing it as 'Getting lost'. Despite the need for further input to make it more comprehensible, some counsellors still experienced discomfort due to the feelings of becoming confused about the communication or losing some of the control. As Sonia acknowledges below, the part omitted could be extremely relevant for the counsellor:

'...No editing! Tell me what they say...I needed to understand what's going on in between...because it is often what is being omitted is as important as what it is said.'(Sonia-67)

I can feel it!

This sub-category acknowledges the efforts of the practitioners in devising coping strategies for missing inputs, fragmentation, untranslated or uninterpreted parts of the conversation and the interpreters' slant. They explained that they closed these gaps by using the skills that they had acquired with experience gained over time. They re-asked the questions and re-checked them with the client and interpreter, but mainly used their common sense to pick them up by observing body language and other non-verbal clues.

'I pick it...by looking at the response and how the interpreter translates it. And I am looking at their eyes in a way that they click in brain, then I will say to the interpreter: 'Can you tell me what you have said...?''(Yan-492)

The literature suggests that mental health professionals are adept at reading both significant verbal and non-verbal clues not only with clients or interpreters but also themselves (Birkett, 2006; Bhui and Morgan, 2007). Stevensen and Holand (2008) concluded that working through languages enabled therapists to perceive matters in both ways, exercising both otherness and sameness simultaneously.

Organizational Competence

This category concerns the ways in which solutions for the emerging issues and challenges were developed in the pursuit of demonstrating organizational competency as a response. The counsellors argued that competencies were needed both individually and organisationally; some counsellors therefore felt that working with practitioners with multiple languages and a wide range of counselling skills could be the answer whereas others felt that the relationship with interpreters should be regulated. The solutions mentioned are grouped as:

- Interpreters accountability 16/5
- Working within intercultural models 15/6
- Working with communities 7/4

Interpreters' accountability

The counsellors asserted that for them to feel more in control, they needed to know more about the interpreters when assessing their suitability for the job and, in some cases, for the client. The participants agreed that they required information about interpreters, and that interpreters needed to learn about how to work with mental health professionals. In doing so, Yan argued that the simplest and the first priority is to examine the interpreters' CVs beforehand to choose the right interpreter. He further asserted that interpreters should be accountable to counsellors so that the interpreters would be prevented from being biased and accountability would provide safety for all:

‘...in counselling, you need accountability. If I am working with X and he does not give me what I want...I can say ‘no’ and then we can go back in next session and get it right. It is very difficult to do that if he [the interpreter] is employed by someone else...’(Yan-367)

Sonia, nonetheless, looked at the issue differently, agreeing that it is the interpreters' duty to do their best, but she disagreed with subjecting them to a similar scrutiny.

‘Their experiences are very different. I think there has to be an understanding and expectation that they would interpret as good as

they can...but they cannot [be] expected to hold to the same standards right back, because they are not counsellors...' (Sonia-389)

The literature shows various methods of ensuring the best practice for therapeutic work involving the use of interpreters; one of these methods is to regard the interpreter as a team member (Dubus, 2009; Tribe and Thompson, 2009) or unite around an organization to be heard (Costa, 2011) so that they would take more responsibility and engage further.

Working within intercultural models

This is another working strategy for some organisations as a response to their circumstances. Counsellors suggested organisations operating in the mental health field adopt flexible, inclusive and adaptable approaches. The abovementioned provisions include learning about and incorporating other cultural approaches and interventions that suit the nature and needs of various communities including asylum seekers, male and female. Yan asserted that organizations should employ people who are multilingual who have diverse skills and wider perspectives, and that they should be working towards developing a 'built-in' policy to maintain quality.

'I think, you need an intercultural model because...by having that in regular basis we are learning from each other and we are able to, therefore, develop whole atmosphere that makes people from different cultures happy.' (Yan-602)

The counsellors elaborated on some of the mainstream therapeutic approaches' unsuitability for addressing diverse client needs. In addition to mainstream practices, integrating tailored, unconventional or complementary therapies were found to be satisfactory procedures. Yigido explains:

'Especially men like non-talking therapy because it is freshening and [an] exercise for them...When they do physical activity, their body feels better, and they start talking.' (Yigido-724)

These are not uncommon practices in mental health. Research has shown that some counsellors working with refugees used specific techniques such as creativity, using metaphors and ritual, and body therapy in working with trauma resulting from rape and so forth (Century et al., 2007).

Working with communities

The counsellors further suggested being proactive in understanding people as a strategy. They explained that to do things effectively and to have a say, it is important to develop competence in the field by enhancing on understanding of clients, and communicating these concerns to relevant authorities to improve the services. For Yan, specialisation was an answer:

‘...it needs to specialize on certain things...because if you get good at something, then that’s the thing you should be concentrating on...’(Yan-526)

Rosie provided another dimension as to how mental health professionals could possibly understand clients within their mental and emotional constructs. She argued that mental health professionals could effectively gain sound knowledge about and an insight into clients and communities by going and living with them for some time. This ethnographic approach would enable individuals, clients, communities and organisations to gain more confidence.

‘...who better to train them than the people of the community? That’s what I say, uhm, you cannot read the manual book and say ‘Right, ok, it’s easy’. You are gonna work with a heart; counsellors are working with the core of what’s going on.’(Rosie-401)

McLeod (2001) noted that although ethnographic approaches were not commonly used in counselling and psychotherapy, they held potential value in terms of capturing live interactions between the counsellor and client in each context.

Jack of all trades!

This category focuses on further technical and practical issues that were perceived as challenging. These ranged from working under and within organisational culture to dealing with constantly changing managerial arrangements. The counsellors stated that they had to work under substantial organisational constraints, and experienced various difficulties regarding working with interpreting agencies and interpreters, arguing that the ways of organisations set up, their approaches, and staff perspectives influenced their practice and hence the outcomes. The challenges are summarized in two sub-categories:

- Use of untrained interpreters 19/6
- Working through organizational constraints 17/4

Use of untrained interpreters

This is a common practice despite its well reported consequences. The counsellors were frustrated about some of the unregulated practices like sending untrained interpreters for mental health interpreting, being forced to work with family members or friends, and dealing with the ways in which interpreting agencies operated. One counsellor claimed that some agencies even did not allow counsellors to have contact with interpreters prior to sessions, which frustrated them as they felt that briefing was important for both the interpreter and the counsellor.

‘... when the triage comes into the room for counselling, client and interpreter..., that will be the first time they meet.’(Flora-294)

The literature shows that these practices are costly and may lead to poor therapeutic outcomes (Stallabrass, 2011; Costa, 2011), and that they are time and effort consuming. Because of that they are described by some counsellors as ‘inferior’ or ‘compromised’ (Century et al., 2007).

Working through organizational constraints

The structure and culture of the organisations involved influence employees, practices and the interpreting and therapeutic processes. Some participants emphasized that they had to work through various constraints that include bureaucracy in paper work, limitations in activities and time and other managerial arrangements. Jane explains:

‘...it’s about finances....It’s rushing until to get the next person in the seat so that you can get another...This is my experience...with the NHS...Therapists are under pressure to get the clients seen and out without taking the time! ...’(Jane-241)

Jane described her situation as ‘wearing many hats’ while trying to help the clients. The counsellors were inadvertently obliged to undertake relatively non-clinical tasks such as filling out forms, writing letters and making phone calls on behalf of clients. These findings are very much in line with the literature (Miller et al., 2005; Tribe and Thompson, 2009,

Century et al., 2007). These activities apparently prevented them delivering much needed therapeutic help, and as described above, it felt very much compromised.

The impact of historical events

This category concerns the issues related to race and culture. Culture or ethnicity refers to the customs, social practices including the religion that a person chooses to follow. Conversely, race refers to those characteristics over which we have no choice (Marshall, 2004). Some counsellors elaborated on the long-standing impact of racial and cultural issues even on contemporary matters within the interpreting and mental health fields. Participants' responses were clustered in two sub-categories:

- Don't remind me of the past 15/1
- Attitudes to be changed 9/4

Don't remind me of the past

This sub-category notes how past events such as slavery and racism are still reflected in our personal, interpersonal and organizational affairs. It considers the underlying causes for racially motivated attitudes and practices. One participant linked the use or non-use of interpreters by the institutions with these historical and political dynamics. She argued that the resistance to providing proper language services has a long history, which involves more than the standard argument that is costly. Using interpreters could reveal the presence of discriminatory provisions, and this resistance could be regarded as a reminder that racism still exists, and cannot easily be ignored.

'...the institutions need to get interpreters. But it is costly...It creates friction; it touches on whole issue of racism...We tend to hold all the nuances whatever created by racism, culture so that they can carry on. When we stop doing that, don't learn English, and we don't comply with others, they then are faced with 'Oh my God! We are going to have make a special allowance for...[people] who don't speak English! ...Here, we are providing a magnificent counselling services and they are gonna come and show where we are going wrong... So, there is always uhm resistance...'(Sonia-455)

She detailed the difficulties of black clients particularly in terms of accommodating themselves within the wider society either with or without realizing their racially troubled background. Sonia depicts how things have been for them:

‘...it touches a place that they don’t want to engage with...Because...you make people here and now have to deal with the fact that their ancestors were bastards and violated! ... Teachers thought that they were animals and behaved appallingly. And asking for an interpreter now brings back all of that. They can go along mild ...; they are magnificent because they were providing all these wonderful services, people are caring, liberal, but the minute they talk about interpreters... you actually now saying the reason why people are here is because you all historically were nasty people...and unconsciously all of that comes to the fore...’(Sonia-485)

Britain shows a particular experience with people from Black and Minority Ethnic backgrounds within its institutions and in society. The psychotherapeutic neglect of minority groups is argued to be a particularly British phenomenon in which access to mental health recourses is determined partly by wealth and education and partly by racial identity (Kareem and Littlewood, 2000). However, visible or invisible racism, having a past linked with slavery, being subject to discrimination, humiliation and denial of the real problems have led to many issues being unresolved. To Marshall (2004), racism as a theory-based stance constructed unbridgeable differences between ethnic groups, hence giving way to social exclusion, segregation and persecution.

Morgan (1998) detailed how we may find ourselves in others, for example, black patients discovering their own internalised racism which was reflected in their behaviour of searching for a White therapist due to their own denial of Blackness. Thomas (1992) hence suggested that knowing clients’ pre-transference constructs is vital as these are triggered by myths, fantasy, and how they are popularized.

The relationship between BME groups and mental health professions in Britain has long been recognized as being problematic (Lago, 2011). Bhui and Morgan (2007) therefore suggested mental health professionals attend race-based transferences of clients and be made aware of their own too in today’s multi-racial and multi-cultural society.

Attitudes to be changed

This sub-category concerns individual and organisational attitudes and practices in relation to educating and training the practitioners. All the counsellors agreed that commonly held misconceptions about others are reflected in the development of courses, reflecting the culture of institutions. Yan argued that working with diverse and ethnically different clientele is yet to be invested in further. He concluded that it is the outdated and rigid unwillingness to engage with wider society, which is preventing people from changing their approach.

‘...particularly the white middle class tend to opt out, ‘not my problem!’. I mean, if you have any cultural course in university, you find everybody from BME community would go to them; everybody white doesn’t...’(Yan-633)

For Sonia, racial matters affect people’s expectations, imaginations and practices, including in the counselling and therapy field.

‘...we know that if you have a white therapist, black whatever, there is going to be a dynamic and the other way around. One of the things I have [a] lot of white people have real issues about being black, and not even realizing they did until it came out within sessions...’(Sonia-460)

People belonging to the host culture may not necessarily pay attention to how others think and feel unless they are trained to do so. The literature on this shows some hesitancy in practitioners in terms of working with others cross-culturally and cross-racially (Lago, 2011; Tribe and Thompson, 2011). Stevens and Holland (2008) reported the impact of political correctness, arguing that therapists’ fear of being regarded as racist functioned like a block that hindered the therapeutic process. Marshall (2004) explained this avoidance by staying away from the ‘other’ from a racial perspective, likening it to the fear of the unknown, the different. He asserts that this is an outcome of a long and ingrained process of socialization through which white values, communication patterns, life-styles and family structures are upheld as preferable and therefore normative (p.60).

Theme C: Good practice issues and recommendations

This theme concerns the professional issues regarding good practice, professional and personal qualities. It reports the participants' recommendations and consists of five main and sixteen sub-categories with two hundred and two meaning units. They are presented in the Table 18 below:

THEME C: Good practice issues and recommendations		
Main Categories	Sub-Categories	Number of Meaning Units / Number of Participants
Expected competencies: Counsellors	Flexibility & Fairness	20/7
	Self-education	17/7
	Assessment skills	16/4
	Emotional maturity	10/3
Expected competencies: Interpreters	Knowledge on counselling	19/5
	Professionalism with passion	15/7
	Linguistic skills	6/4
Identified needs: Interpreters	Training	16/6
	Recognition	13/6
	Supervision	13/6
	Briefing and debriefing	8/4
Identified needs: Counsellors	Tailored supervision	14/6
	Training and experience	12/5
Further recommendations	Better promoted courses	10/3
	Networking	7/3
	Leadership	6/3

Table 18: Theme C (Counsellors): 'Good Practice Issues and Recommendations'

Expected competencies: Counsellors

Participant responses show that the counsellors' expectations of themselves and of other counsellors and interpreters cover a wide range of skills, attitudes and competencies. These

include the abilities to employ core counselling skills, to undertake appropriate and relevant needs and service assessments, to assign clients for tailored services, and, finally, the ability to educate themselves. These competencies are clustered in four sub-categories:

- Flexibility & Fairness 20/7
- Self-education 17/7
- Assessment skills 16/4
- Emotional maturity 10/3

Flexibility & Fairness

Counsellors asserted that listening with care requires attention to details and differences, creativity in offering other means of explanations and hence solutions. The participants suggested going beyond the boundaries of standard practice routines, and argued that being open minded, fair and unbiased towards the clients' needs and emerging stories helped them to understand them. Jane regarded it as attending the client's own world:

'...I accept the clients' frame of reference: how they are, their beliefs are, and I come into their world. It doesn't change how I would handle my session, how I would treat them, and I would approach them...'(Jane-83)

In the counsellor group, all participants were either multicultural or multilingual by background. They acknowledged the necessity of being open-minded and adaptable in their practice. The results show that the counsellors extensively exercised new thinking modes and approaches to the varying nature and the needs of their clientele. Some psychologists explain this as a result of being bilingual or multicultural, arguing that multilingual people are more open to the various thoughts, actions and solutions than monolinguals. Kharkurin (2012) concludes that bilingualism enhances cognitive functioning.

Dewaele (2016) has taken the argument further by looking into the relationship between multilingualism/multiculturalism and personality traits. He along with other applied psychologists argued that multilingualism and multiculturalism do not only increase cognitive abilities and creative behaviour but also shape the individual's personality. For example, in one study they found that a high level of multilingualism provides individuals

with better skills in dealing with ambiguity (Dewaele & Li Wei, 2013a); similar studies reported that proficient users of several languages scored significantly higher on the scales of Open-mindedness, Cultural Empathy, Social Initiative, Emotional Stability and Cognitive Empathy (Korzilius, Van Hooft, Planken and Hendrix, 2011; Dewaele & Li Wei, 2012; Dewaele & Stavans, 2014).

Self - education

Participants agreed that they should enhance their understanding and knowledge of their clients and communities, and that it was mainly an individual's responsibility to learn by visiting local cultural and faith places such as churches or mosques, and attending relevant events and trainings.

‘...go and read up books, go and talk to communities...so many in Birmingham now...you have got organisations now that designed for Black community, Asian community, Irish community...’(Rosie-475)

Another counsellor argued that learning about the clientele group purely the responsibility of the practitioner. Burchell (2009) suggested that the socio-political context from which clients' problems have originated must be recognised and dealt with through reading. However, learning and application should be in moderation and Birkett (2006) warned against putting extraordinary effort into coping with the differences. Birkett also argued that excessive sensitivity may discourage counsellors to follow and act on prejudgements and assumptions regarding clients' age, sex, ethnicity and class. Chantler, Gangoli and Hester, (2009) similarly questioned the term of cultural sensitivity, asserting that the notion of cultural sensitivity suggested that cultures were fixed and static rather than a dynamic and evolving entity.

Assessment skills

A comprehensive assessment in a multi-cultural and multi-racial context goes beyond the standard counselling practices of active listening, acceptance and empathy. The counsellors emphasized that an informed assessment involves entering the world of the client, going to the deep roots of their distress by taking clients' personal history as much as they could and including the clients' understanding of mental health and stress, their support mechanisms and help-seeking strategies.

‘...for the assessment you have to ask questions, uhmm...about their life, life style, what’s working for them, what’s not working and uhm what are their support mechanisms... asking what helped in the past, how can they use that again...?’(Jane-98)

A therapeutic conversation is no more than a slowly evolving and detailed, individual life story stimulated by the therapist’s position of not knowing and the therapist’s curiosity (Anderson and Goolishian, 1992; p. 38). Some authors elaborated on what a robust assessment should involve, suggesting therapists assess clients’ preconceptions about race and ethnicity, their conceptualisation of mental health, self and their family and community (Bhui and Morgan, 2007).

Emotional maturity

Working with and through emotionally charged material throughout the triadic therapeutic process challenges counsellors in terms of locating and coping with their own feelings. Counsellors mentioned a wide range of feelings including ‘engaged, confident, comforted, reassured, in control, hopeless, worried, stuck, unsure and frustrated’. Maria named another common yet non-vocalized feeling of being judged expressed by the counsellors. Ways of handling these were argued to have emotional maturity and empathy. Jane and Yan explain:

‘... while outside of the room, there is chaos and there is cutbacks...but a good counsellor would stay with the clients.’(Jane-252)

‘...if you are enthusiastic and taking interest in people, you will get a response from people. They have got to feel that you are interested in them.’(Yan-612)

It was important for them to be perseverant in striving for the therapeutic alliance with clients and interpreters, and these are deemed to be emotionally and mentally daunting. They must be passionate, positive and curious. It also was important for the participants to be able to cope with uncertainties that were inherent in the process. Some therapists termed it ‘working out of their comfort zone’ as this could bring unexpected dynamics to the sessions if not anticipated (Stevens and Holland, 2008).

Expected competencies: Interpreters

Counsellors' responses also reveal that interpreters too should acquire and demonstrate certain personal and professional skills and competencies. Miller et al. (2005) summarised that the required skills of the interpreters in mental health are similar to those possessed by psychotherapists. These skills and commitments include competency in linguistic skills, the ability to cope with sensitive issues and the process, aspiring for the best practice and gaining sufficient knowledge about both interpreting and mental health. Their responses are further clustered below:

- Knowledge on counselling 19/5
- Professionalism with passion 15/7
- Linguistic skills 6/4

Knowledge on counselling

Overall it seemed that informing interpreters about the tenets of counselling and mental health throughout the process was felt time-consuming and depletion of exhaustion of resources. The counsellors too claimed that interpreting for counselling differs from interpreting in other contexts and therefore interpreters must widen their knowledge of mental health in general, and of counselling and therapy.

‘...it can often be about that they are not actually understand the subtlety of therapy. What is it, what was I trying to do, and the process of therapy itself? ...’ (Sonia-39)

The counsellors expressed the opinion that the interpreters should be knowledgeable about how to convey emotions in the target language, make sense of non-verbal clues, and handle open-ended questions effectively. Miller et al. (2005) suggested interpreters learn to appreciate the value of psychotherapy as an approach to healing. Many community organisations across the UK have acknowledged this need and are working towards lessening the burden on the system by working with both statutory institutions like NHS and local interpreting agencies in order to train interpreters with more specific information (Costa, 2010; Stallabrass, 2011).

Professionalism with passion

The participants accentuated that interpreters need to be enthusiastic, curious and motivated. Being passionate is claimed to be important as it involves a willingness to approach and learn more about the clients and the context in which they are working, and being ready to work flexibly with others. One participant added that interpreters' professionalism and maturity could make sessions easier for all members of the triad as they would know what could come up, and how to deal with it. Yan highlighted that enjoying the work is essential for therapeutic engagement:

‘...when I work with an interpreter, it really works. Because they love what they are doing. You gotta love what you are doing to create that therapeutic alliance....you got to be absolutely passionate about what you are doing.’(Yan-692)

Miller et al. (2005) suggested that interpreters should be trained with a specific model of interpreting for working in psychotherapy settings which would boost their professionalism and enhance their engagement.

Linguistic skills

The counsellors relied on the interpreters' language skills, such as having good command of English and of their own language, on their ability to use the right terminology and convey the meaning into both languages accurately, and therefore the interpreters must be competent in these skills in both languages. Zishan highlighted its absence:

‘...some of the interpreters I have met, their English is not as good...there was times that I had to explain to interpreter myself what I am to say...’(Zishan-162)

It should be noted that interpreters' language skills are shaped and informed by the context and the modes of interpreting they adhere to. The modes of interpreting and their conceptualisation may vary; for example, while in linguistic mode or conduit mode, interpreters provide word-for-word translation of what was said only whereas in cultural brokering mode, they further add the relevant cultural and contextual meaning and variables to it. Therefore, some perceive them as the managers of the cross-cultural mediated clinical encounters (Avery, 2001; Tribe & Morrissey, 2004).

Identified needs: Interpreters

Based on the counsellors' experience, interpreters needed to be informed about clients and what was to be done with the client and the interpreter, supported with appropriate attitudes, relevant training and supervision. Counsellors argued that if these were in place, interpreters would be helped in achieving their personal and professional development. These identified needs are clustered in four sub-categories below:

- Training 16/6
- Recognition 13/6
- Supervision 13/6
- Briefing and debriefing 8/4

Training

It was the participants argued that interpreters should not only regularly update themselves in their linguistic skills but also do so in their understanding and knowledge of core counselling skills. Maria, Sonia and Yan particularly emphasized the need for learning how to handle emotions and transferences as well as working within personal and professional safety. Rosie summarized it:

‘They need to have those kinds of skills, boundary skills...which is why the interpreters need to have the correct type of training, they need to be aware of... and their limitations in counselling as well.’(Rosie-421)

An interpreter training programme should include the theory and methods of psychotherapy, relevant terminology, care provisions, strategies of self-care, ways of recognizing and managing emotional reactions and handling uncertainties (Miller et al., 2005; Costa, 2011). Al-Ansari, Newbigging, Roth and Malik (2009) argued that interpreters and advocates alike are subject to a lack of accredited courses, which has an impact on the provision and quality of services as the organisations tend to turn to untrained interpreters.

Recognition

This sub-category reflects the concerns that the work of interpreters is undermined or unacknowledged. The counsellors agreed that interpreters were not always treated with respect and are not professionally recognized by staff, interpreting agencies and the institutions they work in. The participants shared this view that an interpreter could provide a good role model for clients, and be a safe attachment figure and a reliable bridge for practitioners. One participant shared that the reasons for interpreters feeling the lack of professional recognition or experiencing dissatisfaction were related to inadequate remuneration, a lack of strong representation and no or few opportunities to enhance their skills.

‘...if you have a room full of interpreters and say that there is a training to be a counsellor...most of them would put their hands up, they would prefer to be counsellors rather than interpreters...’(Yan-684)

Despite their invaluable input and the complexity of the interpreting tasks and skills required to handle the dynamics of a triadic therapeutic relationship, interpreting and interpretation is described as a low-status occupation particularly in institutional contexts (Drennan & Swartz, 1999), is paid poorly and irregularly (Granger and Baker, 2003); also some interpreters suffer from a lack of empathy in clinicians (Tribe and Thompson, 2009). Al-Ansari et al. (2009) concluded that a lack of skills development and of opportunity for career progression can potentially give rise to ‘lower status’ feelings in advocates and interpreters in relation to other health workers.

Supervision

Participants identified the immediate need for interpreters to have supervision. They described cases in which both clinicians and interpreters found it difficult to cope with difficult subjects such as breaking the news of a terminal cancer diagnosis to a client or, as Yan experienced, a case where interpreters may need to know why clients’ limbs were blown up. In these cases, interpreters would need not only a supportive supervision but also to be reminded of the safeguarding issues. Maria gave some details:

‘I think without a shade of doubt there should be a pastoral kind of supervisions and clinical kind of supervision. So, you are helping

them to understand what the clinical processes are, and also helping them to understand some of their own vulnerabilities and how they are going to manage that.’(Maria-155)

Receiving support and regular supervision have further significance for interpreters when working on trauma particularly as compassion fatigue or secondary trauma in interpreters was primarily found to be correlated with poor support received (Salihovic, 2008; Costa, 2011), and furthermore, interpreters may find themselves as witnesses of human rights abuses (Blackwell, 2005; Holmgren, Sondergaard & Elklit, 2003), which cannot be left alone to be processed by the interpreter himself or herself.

Briefings and debriefings

The counsellors also agreed that interpreters must be adequately informed about clients’ conditions and background or case details before entering the room, and debriefed after the complex cases to check if they wanted to talk about anything. This would help their perspectives on the cases to be heard and possibly documented. Sonia claimed that exchanging views on how to work will help interpreters to adapt their linguistic skills and styles. They argued that interpreters should be informed about how and from where they can get relevant information and the support they needed.

‘...the clinicians should give them debrief and should have material and the information about where they can go. So, there are other agencies where they can go for support...’(Maria-327)

Flora further added that even for non-talking therapies, interpreters should be informed about what and how to proceed.

Identified needs: Counsellors

This category further reports what the participants thought about their own needs. The counsellors claimed that they needed support in taking care of and updating themselves through relevant training and ever-evolving supervision. Their responses are grouped in two sub-categories:

- Tailored supervision 14/6
- Training and experience 12/5

Tailored supervision

This sub-category reflects the increasing supervision needs of counsellors who continually face new forms of human suffering and are obliged to be creative in working with various practices and guidelines. The counsellors argued that they needed to offload their anxieties by talking about the cases they encountered and/or may encounter, and to ask for further guidance. Some participants asserted that typical supervision practices may not be sufficient due to the ever-changing nature of the work and the needs of clientele. The challenges here range from adapting already stretched services to counsellors' needs for a tailored support in the form of supervision. Rosie reflects on her experience.

'I would like to see more Asian supervisors...Because you are doing your work, then you'r doing languages. Then your supervision is with somebody [who]doesn't understand you...It's one of the constraints...If my supervisor was Asian, then I would not have to go around, long winded story, the supervisor would already have that knowledge and it would cut out my chase of having to explain.'(Rosie-495)

Mental health professionals are affected by their clients' issues and the emotionally-charged processes. They thus suffer from secondary trauma as a form of negative counter-transference (Burchell, 2009) and 'compassion fatigue' in an ongoing empathy towards traumatised clients (Salihovic, 2008). Supervision would be the safest place and route to overcome these difficulties. It has been also argued that group supervision might be an effective way of 'offloading' for counsellors to avoid burnout. Westmeyer (1990) suggested the utilization of the skills and experiences of more experienced bilingual practitioners by having junior clinicians observe them.

Training and experience

The counsellors argued that their work required training to be regular and updated so that they could provide an informed service and to feel confident. Although all participants had relevant counselling training, the majority of them did not have appropriate training towards working with BME clients. They suggested that training topics should cover the areas of awareness of ethical and safeguarding issues, working with diversity, the assessment of needs and how certain models work or do not work.

‘...I do recommend training and just to make aware, bringing awareness; things can go wrong and how to manage these.’(Jane-368)

Century et al. (2007) reported some counsellors working with refugees created their own ways and methods of helping. Wade and Bernsteins (1991) investigated the effects of therapists’ cultural sensitivity training on African American clients. The main effect of training was that clients who saw culturally trained therapists rated the therapists as having greater expertise, trustworthiness, attractiveness, empathy and unconditional positive regards than clients whose therapists were not given that training. D’Andrea, Daniels and Heck (1991) suggested that perhaps if the training is sufficiently intense, the specific length and number of sessions will have little or no effect on the outcome.

Training regarding working with interpreters has been accepted by many professional organisations such as the British Psychological Society, the Royal College of Psychiatrists, and the British Association for Counselling and Psychotherapy as part of their core curriculum (Tribe and Thompson, 2011).

Further Recommendations

This category concerns the recommendations made by the counsellors in relation to improving themselves and their services. The suggestions include long-scale policy changes and the development of courses on a small scale. These are presented in three sub-categories:

- Better promoted courses 10/3
- Networking 7/3
- Leadership 3/3

Better promoted courses

Some counsellors in particular underlined the need for more inclusive courses and services for all communities, for example non-talking therapies for men. Yan summarized that as the socio-demographics of the society is changing, so should the services.

‘... there are courses, what’s the awful is that a lot of the cultural courses are non-compulsory, and I think they should be compulsory,

as opposed to be optional, particularly psychology and counselling...'(Yan-631)

Some participants claimed that the advertisement of the courses targeting cross-cultural matters and communities was not extensively communicated and that therefore its effect in terms of uptake was weak. Nevertheless, people should have access to these courses through a wide range of publications. Costa (2010) similarly suggested the interpreters training curricula be revisited.

Networking

Some counsellors observed that interpreters were not well heard, represented and equipped, and therefore should unite by establishing their own support mechanisms or organizations to have a greater role in dealing with emerging issues and coping better with challenging cases. The counsellors indicated that even when they had issues regarding the interpreter's welfare or any wrongdoing, there was no appropriate authority to approach. Maria argued that interpreters might also need to reach decision-makers like commissioners to educate them about their needs and aims. She noted that interpreters do not talk to other interpreters, which leaves them isolated:

'I don't think that they are going to have much success individually...So I think, they can maybe get together with a group to do something...They have no power at all I guess what they could do is mainly form peers support together with other interpreters...'(Maria-341)

The literature shows a call for organisations to take the lead in negotiating and delivering the needs of interpreters (Lipton et al., 2002). Organisations should act on behalf of interpreters by consulting their staff about the ways in which the codes of conducts and guidelines are delivered (Tribe &Thompson, 2009). In a wider context, Holmgren, Sandergaard and Elklit (2003) recommended humanitarian organisations review their policy and inform the agencies regarding the use of interpreters and how to support them.

Leadership

The participants agreed that for the development of an improved curriculum and education, leadership is needed. This however requires further effort to get the attention of the policy-

makers. Yan below added that policy change could be achieved only through discussions on how to develop better tailored courses and services:

‘...I think that’s a problem that you don’t have tutors in colleges that have a lot of experiences and ambition...I mean they have to have that debate in curriculum in universities and colleagues, and by publishing or writing articles...’(Yan-658)

For policy makers to tackle the inequalities and exclusion hidden in different layers of society, they need to challenge the ‘one-size-fits-all’ approach (Kings Fund, 2006) as this leads to disparate care, hence creating a ‘marginalised position in society’ (Quickfall, 2004; Psinos, Hatzidimitriadou, Butler and Barn, 2011). Innovative academic courses for interpreters and advocates should be developed to eradicate inequalities and the lack of career opportunities (Al-Ansari et al. ,2009).

Summary of the counsellors’ data

The participants were mainly concerned with the unpredictable nature of the therapeutic and interpreting processes. The difficulties experienced were mostly caused by the presence of the third person, being dependent on the interpretation provided and by the clients’ presenting characteristics and problems. Interpreters at times were regarded both as a great help and as obstacles undermining the practitioner’ confidence. However, when adopting a scholar and mature attitude, the participants experienced the whole process as a learning curve with the satisfaction of the shared personal and professional development.

The results indicate ever-changing feelings, opinions, actions that were presented by all members of the triad. This very nature of the process appeared to make them feel cut off from the process due to unexpected stories and the realities of the clients’ situations/problems and the complex relational dynamics.

Importantly, the participants extended the underlying reasons for the difficulties encountered to a wider perspective, arguing that the roots of the unjust and inadequate services originated from historical events and political factors such as slavery, and then institutional racism, which have shaped the service provision even in modern times.

The counsellors acknowledge that triadic therapeutic work requires extended personal qualities and professional skills to manage the processes with a shared satisfaction for all.

Their needs were in line with the findings from the literature that they required regular training and tailored supervisions in order to be up to date.

The themes also illustrate the participants' further suggestions in their pursuit of trying to find solutions for their difficulties. These include better leadership in making comprehensive decisions in the education and mental health area, further networking activities for interpreters and better prepared and tailored courses that match the needs of the broader and more diverse trainee profiles.

CHAPTER 6: FINDINGS FROM THE CLIENTS' DATA

This chapter reports the findings of the analyses of the data collected from the in-depth interview group with the clients. First, the socio-demographic information of the clients and the statistical findings will be given. Then the themes and the categories will be reported with relevant explanations and the quotes from the participants.

This section will end with a summative account of the themes.

Socio-demographic findings

Statistical information relating to the clients in the interview group is as below:

Six of the nine clients were female, 3 were male. The average age was 45.33.

Only one of the participants had a higher education degree. Six were Turkish, two were Bosnian and one was Kurdish. Eight of them were bilingual and one was monolingual. Table 19 shows all the information provided by the participants.

The table also shows the information requested from the clients during the interview about the counsellors and interpreters they worked with during the talking therapies they had. The clients had been informed about what to expect from the interview in the information letter that was sent to them before the interviews, but they were again reminded, on the day of the interview, to also focus on a session that they would like to talk about with a counsellor and an interpreter.

Socio-Dem. Variables	Gender	Age	Occupation Full Time/ Part Time	Education	Ethnicity	Language (s) Spoken	Counsellor worked with Gender/Age	Counsellor Occupation/ Ethnicity	Interpreter worked with Gender/ Age	Interpreter Occupation/ Ethnicity
Pseudonym (s)										
Kiraz	<i>Female</i>	47	<i>Housewife</i>	<i>Primary</i>	<i>Turkish</i>	<i>Kurdish/ Turkish</i>	<i>Male- 35</i>	<i>Counsellor/ English</i>	<i>Female- 35</i>	<i>Interpreter/ Turkish</i>
Ayisigi	<i>Female</i>	31	<i>Housewife</i>	<i>Secondary</i>	<i>Turkish</i>	<i>Turkish</i>	<i>Female</i>	<i>Counsellor/ English</i>	<i>Female- 40</i>	<i>Not Known/ Turkish</i>
Ozay	<i>Female</i>	50	<i>Housewife</i>	<i>Primary</i>	<i>Turkish</i>	<i>Turkish/ Kurdish</i>	<i>Female- 50</i>	<i>Counsellor/ English</i>	<i>Female & Male 30 &50</i>	<i>Interpreter/ Varied</i>
Martin	<i>Male</i>	38	<i>Worker /FT</i>	<i>College</i>	<i>Turkish</i>	<i>Turkish /German</i>	<i>Male- 65</i>	<i>Therapist/ Indian</i>	<i>Female- 44</i>	<i>Interpreter/ Turkish</i>
Slimlady	<i>Female</i>	38	<i>Housewife</i>	<i>University</i>	<i>Turkish</i>	<i>Turkish /English</i>	<i>Female- 40</i>	<i>Therapist/ English</i>	<i>Female- over 35</i>	<i>Not Known/ Iranian</i>
Perihan	<i>Female</i>	41	<i>Housewife</i>	<i>Primary</i>	<i>Kurdish</i>	<i>Turkish/ Kurdish</i>	<i>Male- 35- 40</i>	<i>Counsellor /English and Turkish</i>	<i>Various/ Various</i>	<i>Interpreter/ Turkish</i>
Safiye	<i>Female</i>	43	<i>Worker/ PT</i>	<i>College</i>	<i>Turkish</i>	<i>Turkish/ English</i>	<i>Female- 35</i>	<i>Counsellor/ Indian</i>	<i>Male- 30s</i>	<i>Interpreter/ Turkish</i>
Roky	<i>Male</i>	65	<i>Electrician</i>	<i>College</i>	<i>Bosnian</i>	<i>Bosnian/ English</i>	<i>Male- 60</i>	<i>Not Known / Pakistani</i>	<i>Male- 30</i>	<i>Not Known/ Bosnian</i>
Baz	<i>Male</i>	55	<i>Electrician</i>	<i>College</i>	<i>Bosnian</i>	<i>Bosnian/ English/ Russian</i>	<i>Female- 35</i>	<i>Psychologist /English</i>	<i>Female-25</i>	<i>Student /Bosnian</i>

Table 19: The socio-demographic characteristics of the clients.

Findings from the Thematic Analysis

In this chapter, socio-demographic characteristics of the clients and the findings of the thematic analyses are presented. Two themes were identified: Theme A: ‘Challenging but helpful’ and Theme B: ‘Organisational and Good Practice Issues’. There are eight main categories and eighteen sub-categories with four-hundred and three meaning units in total. The themes and categories are explained and quoted in detail below.

Theme A: Challenging but helpful

This theme captures the complex and contradictory nature of the triadic therapeutic relationship and the interpreting process. The responses show that they evaluated the whole process in a critical manner by providing both positive and negative insights into their experiences. The clients recalled the ways in which the counsellors and the interpreters communicated and understood them, and how they judged their actions throughout the encounters. Clients further reflected on how the interpreters and counsellors presented themselves, and how they perceived the power dynamics which shaped their relationships.

Theme A theme yields five main and eleven sub-categories with two hundred and ninety-four meaning units, and presented in Table 20.

THEME A: Challenging but helpful process		
Main categories	Sub-categories	Number of Meaning Units/ Number of Participants
Client characteristics	Anxious about confidentiality and trust	57/9
	Physically and emotionally unwell	18/5
How I knew thatthey did NOT understand me	32/9
	...they understood me	28/9
Impact of the interpreter	‘I wish I wasn’t here!’	31/8
	‘I felt relieved!’	26/8
Clients’ perception of power and the counsellor	Who had the control?	20/9
	Having expertise and authority	17/5
	Putting the clients off	14/2
Evaluation of the process	Emotional, long and disconnected	33/8

	Helpful and informative	18/7
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Table 20: Theme A (Clients): ‘Challenging but helpful process’

Clients’ characteristics

This main category concerns the profound impact of trust issues that were triggered by confidentiality and translation related matters on the therapeutic process. Clients attributed some of the dynamics that had an adverse impact on them to themselves, recognizing the influence of their multiple difficulties, attitudes, beliefs and emotions on the whole process. Some described it as if they were not themselves, due to the many changes in their minds and their lives. Some studies term this phenomenon ‘culture shock-conflicts’ appearing in the lives of refugees who flee from their countries (Derman, 2009; Cinar, 2013). Client responses were clustered in two sub-categories:

- Anxious about confidentiality and trust 57/9
- Physically and emotionally unwell 18/5

Anxious about confidentiality and trust issues

The most important matter for the clients was confidentiality and this was continuously reflected throughout the interviews. This sub-category explains how the trust issues are deep and widespread among this client group. The clients reported a wide range of anxiety that resulted in being unable to trust the members of the triad, the translation provided, and the process. They were apprehensive about which interpreter was going to come in, and this was a major concern for clients who came from war-torn zones or who came to the UK as a result of political persecution in their country of origin. They were careful about what they said and with whom they shared their accounts. This triggered the anxiety of being misrepresented to the counsellor and thus being misunderstood. It was also difficult for clients to work with an interpreter who represents the other side of the political argument in their home countries. They were worried about trusting interpreters as to whether they could keep the information confidential because of the possibility of being heard within the community.

‘I already have a trust difficulty because I came to this country alone when I was young and have gone through a lot...Therefore, I could not

trust the interpreter as well. I was only able to say 75 % of what I really wanted to say...'(Slimlady-47)

This was particularly important for political refugees who came from war torn countries: for example, it was possible for a Bosnian client to have a Serbian interpreter who was therefore perceived to belong to the other side of the political argument. Similar transference feelings towards interpreters were reported and it was argued that this was partly caused by belonging to a small community (Silver, Portnoy and Peters, 2015; D'Ardenne, Farmer, Ruaro and Priebe, 2007).

Another source of client anxiety was whether the translation would be accurate, and whether the interpreters were biased as most of them felt that the interpreters either shortened or omitted what was said. The clients were concerned that whatever they told the interpreters and what the counsellors relayed through the interpreters was not translated as accurately as it should have been.

'...what I don't like in interpreters is that their version of the conversation is always shorter than the counsellor's...He was talking to the counsellor for 3 to 5 minutes, but he was answering with one or two words only.'(Baz-227)

Trust issues appeared to be endemic amongst this client group. One participant justified his lack of trust of mental health professionals by explaining that they did not keep the promises that they had made. He however acknowledged that that largely depended on the resources that service providers had. Given the distress that these clients had experienced and the amount of help they needed to continue their new life, it is hardly surprising that they were upset.

'Yeah, [they] always promised, but nothing happened.'(Roky-52)

Clients responses also show that they were unsure about what the mental health professional was going to do with the information given. Some client experiences suggest that they felt that they could be put in a vulnerable position if matters were to go wrong. For them, it was not only about the accurate translation of what was said during the encounters or about the political accounts of the refugees. It was also about how confidentiality was utilized. Although the researcher did not go into further details here, the following excerpt shows the mind sets and emotional states of this client group.

‘...they tell to you that ‘We will keep [the information] safe. But, if the police will involve...we will share the information.’ When you say that, that’s it! What am I going to tell you? ...I fear that, if anything bad happens to me, they will harm my family and children...’(Perihan-54)

This excerpt shows that this client group needed considerable constructive information about how the system operates in the host country. They tended not to know which authority deals with what issues and information. One participant disclosed to the researcher during the interview that she thought that being on state benefits caused too much scrutiny. Clients were also asked how confidentiality was ensured, and they explained that they were well informed about it at the beginning of the process. D’Ardenne et al. (2007) suggested the use of a clear protocol in their work with trauma clients from all over the world, informing both the clients and the interpreters about the nature of their condition and the intervention to be followed. Some organisations tend to provide translations of what the counsellor would be doing with them.

Physically and emotionally unwell

Clients described themselves as needing help, mainly due to going through social, emotional, psychological and spiritual ordeals as well as to having undergone physical hardship. Although they flagged these up, they argued that neither their psychological disturbances nor physical illnesses were properly addressed. Some felt uncomfortable mentioning their obsessions and hallucinations when interpreters were present. Safiye described her helplessness, using a Turkish proverb, equivalent to the English proverb ‘Beggars can’t be choosers’:

‘...you are in a position that many things are wandering in your brain. You want help! ...It is like... (silence)...there is a saying: ‘a man will grab at even a snake when fallen into the sea.’(Safiye-78)

Hopelessness was common among the clients. Baz had problems with his dreams and similarly couldn’t effectively express himself, arguing that would not be dealt with properly. Perihan summarized her need;

‘...I was depressed, and I needed hope and a happy face...’(Perihan-196)

Perihan's statements remind us of the importance of the well-being of both clinicians and interpreters in terms of their approach and with what attitudes and emotions they should be encountering the clients.

Mental health issues are common amongst immigrants, depending on what situations they were in before they came and how they arrived in the UK; therefore, it is hard to deal with their emerging difficulties (McColl and Johnson, 2006; Greater London Authority, 2005). In a study with Turkish speaking immigrant women, Cinar (2013) found that most participants were not aware of the services provided, and that most of them did not accept that they had any psychological problems. She argued that many were unaware of their needs due to cultural shock and trauma. A Home Office official added that for many asylum seekers' suffering begins when they are dispersed, and this significantly undermines their sense of control (Bloch and Solomons, 2009). D'Ardenne et al. (2007) rightly argues that when working with traumatised clients, attending to their fear and feelings of multiple losses is crucial to the reparation process.

How I knew that ...

This main category concerns the ways in which the clients observed and made sense of the efforts of the interpreters and the counsellors. They were asked about how they became aware of when the counsellor and the interpreter was able or unable to understand them. The responses suggest that the clients were highly attentive to both verbal and non-verbal clues coming from both the counsellor and the interpreter. The clients' ways of verifying these are explained in the following sub-categories:

- ...they did NOT understand me 32/9
- ...they understood me 28/9

... they did NOT understand me

Clients stated that their main way of knowing whether they were understood was to look at the non-verbal communicative behaviours of the counsellors and interpreters, particularly their facial expressions. They maintained that the happiness and stress of the professionals were apparent in their gestures and body language such as eye contact and positioning of their body. Another checking method that they used to verify if they were

understood was being alert to possible mismatches that occurred during interpretations both in terms of the content and the duration of the conversation.

‘...there was an inconsistency between what the counsellor said and what the interpreter conveyed.’(Ozay-39)

Regarding the counsellors’ behaviour, clients firstly, explained that they could tell when they were not understood when the counsellors could not maintain their bodily positions, and turned their head to the other side, away from the client; secondly, they knew from the repetition of questions that the clients were asked, and thirdly by the inconsistent remarks made by the counsellor about the client’s condition or the story they told as in the case of Slimlady.

‘There were so many repetitions that I even myself got bored of that. I felt bored of my own problems...!’(Slimlady-98)

Costa (2010) notes that attunement is an essential element for satisfactory therapeutic relationships. When this is not established then collusion may be experienced. These indicate deep emotional dynamics within the structure of the conversation.

... they understood me

The clients claimed that when the counsellors were attuned to the conversation, they tended to talk more and be more willing to be helpful. The clients added that counsellors then asked the right questions, made notes and seemed to offer the right responses.

‘When he understood, I saw him quickly taking notes, [and] I told myself what a good man he was.’(Perihan-154)

Clients regarded the counsellors who gave practical suggestions for their day to day difficulties as having helped them considerably, which led to more respect for them. Ozay felt understood then because the counsellors’ remarks matched her life situations.

‘I knew it because she was giving me logical and appropriate answers.’(Ozay-35)

It is no wonder that the clients were more satisfied with the sessions when they were given advice by the counsellors. They tended to see and hear practical answers rather than working on emotions and understandings. The opposite is also true that when clients were

not provided with such answers or guidance, the counsellors were regarded as inadequate and questioned their expertise.

In terms of knowing how and when the interpreters understood the clients, they similarly monitored them by focusing on their verbal and non-verbal utterances. They checked whether the interpreters responded sensitively towards the client's story, how long it took to translate the spoken material and if their facial expressions were assuring or friendly.

‘...it is very important to talk to someone who is able to empathize with the feelings of the client rather than talking to a machine. If someone is emotional and closes their eyes, that itself is a bodily message to you!’(Safiye-155)

Stevens and Holland (2008) reported some therapists' misunderstanding of the clients' language difficulties of not expressing themselves fully as part of the process (p.21). As in the case of Safiye above, clients sometimes express their feelings and thoughts through non-verbal clues which must be detected by the practitioners and interpreters. This might also indicate that the clients' lack of verbal expressions might have been misunderstood by the therapists as interpreter-related problems. The therapist might attribute it to their failure (Stevens and Holland, 2008) or to the interpreters' lack of skills.

Some authors maintain that attunement, genuineness and attentiveness of therapists are key in enabling clients to internalize the therapeutic process. Without these qualities, poor outcomes or premature termination of the therapeutic encounters may ensue (Castonguay, Boswell, Constantino, Goldfried and Hill, 2010; Henry, Schacht & Strupp, 1990; Sherwood, 2001).

The clients were equally sensitive to all communicative acts of the interpreters. Miller et al. (2005) noted that interpreters were the first point of contact for clients when they were unwell; hence interpreters must be careful about not presenting themselves as dismissive, judgemental or uninterested in the client.

Impact of the interpreter

This category concerns the interpreters' unavoidable impact on clients, service providers and the process, which can lead to various emotional reactions. The clients were very much aware of the presence of the third person in terms of their positive and negative impact.

They, on one hand, were highly appreciative about having interpreters to be able to communicate, but on the other hand, for some, the worry of being judged outweighed its positive impact. The client responses yielded two sub-categories:

- ‘I wish I wasn’t here!’ 31/8
- ‘I feel relieved!’ 26/8

‘I wish I wasn’t here!’

One of the strongly evoked feelings in clients was shame at not knowing enough English to help themselves. This feeling was mainly related to the fear of being judged by the interpreter, although admiration for the interpreter was also present. They referred to ‘being judged’ as being criticized for not having a good level of English and for having a mental health problem. The feeling of shame was strong.

‘Regret is not helping but I wish I knew the language. We in fact were not that weak or desperate...I feel shame of being in this position...’(Perihan-216)

Some researchers noted that speaking in a different language is about developing different selves and this causes anxiety, shyness and embarrassment in clients (Stevens and Holland, 2008). Not having the right language is a real concern for non-English speaking clients and even for bilingual clients, therefore, as NICE (2005) guidelines asserts, language should not be an obstacle in accessing the services.

Participants viewed some interpreters as judgemental for adding their own thoughts and correcting what the clients said, although they wanted to linguistically and emotionally present themselves as helpful.

‘I think, he was trying to help...But that was the problem. I said to him “Don’t provide your own version.” ... He thought he was going to help.’(Roky-237)

The clients underlined their distrust of the interpreters: not being sure if the conversations would be confidential, and not being sure about interpreters’ professional attitudes during the process. Safiye below shared that she was eager to divulge her agony, but she did not have sufficient information about the interpreter and time enough to establish trust. She

questioned whether the interpreter was a member of a professional body so that she could trust her before disclosing anything.

‘...when you get this kind of appointments, you know why the other individual is coming... We open-up talking about our stuff, secrets... And a third person comes in, then you start thinking: they come because I am not in my country, you have to get on with it...’(silence). (Safiye-95)

Clients were asked what they felt when they first saw the interpreter in the room, and they provided mixed responses. Clients’ transference feelings in a traditional dyadic encounter have widely been reported. Silver, Portnoy and Peters (2015) insisted that the configuration of the triadic therapeutic relationship with the inclusion of the third person puts extra strain on the whole process, making it difficult to apply the traditional transference and countertransference terms to it. Therefore, they prefer to use the term ‘complex emotional reactions’, as emotions are evoked in both clients and therapists towards interpreters.

‘I felt relieved!’

Clients equally expressed their positive feelings towards the interpreters. Although they had ambivalent feelings for different situations, they were clear about what the interpreters meant for them. They described interpreters as a ‘bridge’. They felt empowered by being provided with an interpreter in the first place as they could share their difficulties and receive help. This was especially significant for clients who had waited a long time to voice their problems.

‘...I would not understand everything, I wouldn’t explain anything, I wouldn’t get any help at all.’(Kiraz-13)

They were clear about the importance of trusting interpreters to get the right help. Baz saw this happening only when the interpreter was trusted and the client had positive feelings towards them.

‘If you want the counsellor help you, you must trust your interpreter. You must tell him what you have and your problem.... If you tell him something [else], ...hiding something from him, the counsellor cannot help you.’(Baz-216)

It was evident that all members of the triad had profound complex emotional reactions to each other (Miller et al., 2005). This might however lead to the client getting close to the interpreter if the interpreter violates the role boundaries and the counsellor seems dismissive and distant.

Clients' perception of power and the counsellor

This category describes how the clients perceived the power dynamics that were present throughout the therapeutic encounters. It is evident that the clients' perceptions were influenced by the authority of the counsellors and the institution they were seen in, and by the counsellors' and interpreters' attitudes towards them. Client responses are clustered in three sub-categories:

- Who had the control? 20/9
- Having expertise and authority 17/5
- Putting the clients off 14/2

Who had the control?

The clients had a clear idea about what to expect from the counsellors and interpreters, how the sessions should be handled, and the roles and rules involved. When the participants were asked in the questionnaire whether the counsellor or the interpreter had more control during the sessions, most of them indicated the counsellors. This, however, was only the case when the counsellors tuned in with the clients' feelings and concerns. Most clients also thought that the counsellors had more power because they provided relevant information and guidance and made decisions that affected the client's well-being.

'... [the counsellor] is there to inform me, she would give me information at every time. The interpreter however comes for the language help only...' (Ozay-13)

On the other hand, some clients argued that interpreters had more control as they were the main agent for facilitating the communication. Some described interpreters as 'communication experts' whose presence ensures a mutual conversation.

‘...the interpreter was relaying everything. Otherwise the mental health professional wouldn’t be able to talk to me. I felt more comfortable, then I emotionally felt confident...’(Kiraz-23)

The extended dynamics of the triadic relationships have been well documented. Costa and Deweale (2012) highlighted that therapists might feel powerless particularly when clients spoke for a long time without stopping, and they waited for the interpretation. In terms of interpreters having control, Searight & Searight (2009) concluded that interpreters should not occupy a central position during the triadic encounters. Emillion (2011) noted that interpreters may feel vulnerable when fulfilling the expected ‘powerless’ role. This feeling might be evoked by the similar traumatic experiences that the client and the interpreter had due to coming from same country (Stevens and Holland, 2008).

Problems ensue when the interpreter wants to occupy a controlling position. Interpreters can be supportive when advocating on behalf of clients whose experiences mirror their own. This may improve their working alliance with the client at the expense of the alliance with the therapist. Some seating arrangements may lead to interpreter-client-centred rather than client-counsellor-centred interactions especially in triangular settings where everybody sits the same distance away from each other. In this case, clients tend to look at the interpreters more than the counsellors (Miletic, Minas, Stolk, Gabb, Klimidis, Piu and Stankovska, 2006). However, this might take a different shape when working with highly traumatic subjects.

Having expertise and authority

Client responses revealed a common non-western image of a counsellor. They regarded counsellors as mental health experts who have the knowledge and the expertise. This affected their expectations. The clients found the sessions more helpful when the counsellor informed them about how to utilize the sessions, why they should commit themselves and how to change their unhelpful thinking patterns.

‘H/she understood what was going through my mind so well that s/he was telling me about new and better thinking ways.’(Ayisigi-19)

In the questionnaires, the clients were asked about how they found the counselling and counsellors. Most participants found them sympathetic and non-judgemental. Most shared the view that counsellors behaved professionally towards them. They acknowledged the

importance of trusting the counsellors to be helpful despite many uncertainties. Since most clients thought that the counsellors were experts in their field and had authority, they perceived them to be trustworthy.

‘...We share whatever we have got inside us...You go there to get help...You cannot think...especially when you are going through a stage where you have lost your trust, even to your own family...You wonder if you can trust people outside. But I would think that they would approach you professionally...[and] stay within their professional boundaries.’(Safiye-80)

Every culture has its own image of professions and professionals. The clients’ expectation of expertise and authority from the counsellors goes with the general tendency in Turkish culture that health and mental health professionals are greatly respected and appreciated (Cinar, 2013).

Putting the clients off

The clients reported that working practices, attitudes and communication styles of the counsellors had a considerable impact on the relationship. They provided a mixed picture about this impact: some participants focused on the negative impact of the counsellors’ cultural differences while others focused on counsellors’ professional actions. They explained that the mismatch between the counsellor and the client in terms of cultural and spiritual understanding sometimes led to the clients’ needs being dismissed and for them to feel alienated from the process. In the extract given below, the client’s counsellor insisted on working on the client’s relationship with her husband while the client wanted to work on managing her overwhelming emotions:

‘...you tell her [the counsellors] about your sleeplessness, emotional frustration, difficulties etc., but she was stuck [in] my husband. Maybe, she was right, but that answer wasn’t at that time the right answer for me.’(Slimlady-124)

It is challenging for counsellors to attend to all the clients’ needs even in a dyadic therapeutic encounter let alone in triadic ones. However, the clients in the research sample indicated that they would greatly appreciate having a counsellor with the attitudes of being non-judgemental, empathetic, attuned to, actively listening and smiling to at clients.

Sherwood (2001) found in her research on client experiences of counsellors that clients expected counsellors to be with them, somehow leaving their own ego and personality behind to embrace the client's story. One of the themes that emerged from her research was clients being hijacked by the counsellor's personal agenda.

Some clients, however, interestingly, were influenced by the counsellors' appearance look and the setting of the encounter. One client stated that he found the setting dirty and untidy, which made him feel that the mental health professional was not interested in him. Another participant was appalled when her counsellor fell asleep while she was talking. Slimlady blamed her own attitudes and beliefs about the counsellor, which set them apart.

'...My counsellor...was a lesbian...I could not believe that she would be able to help me...I think this condition is not congenital, doesn't come from the birth but it was a choice made by her. Maybe, I was unable to respect her...' (Slimlady-20)

It seems that the client attributed her dissatisfaction with the counselling to the counsellor's identity instead of the counsellor's work with her. The findings show that clients were sensitive to visual images of the members of the triad and the settings as well. Some literature suggests that there are occasions when the sexuality of the clients may prevent empathy being felt by their counsellors and vice versa (MIND, 2009). Creating a safe therapeutic environment is however a vital prerequisite in establishing a working alliance and trust (Gabbard and Lester, 2003; Peebles, 2012).

Evaluation of the process

This category reports the clients' overall feelings about the process of counselling. Their responses yet again revealed the positive and negative aspects of the therapeutic relationship. Their responses show highly charged thought processes and mixed feelings. The clients described the relationship as emotional, broken, repetitive, long, biased and unfair. However, overall, they found the counselling process and the emotional support they received helpful and enlightening. Their responses are subsumed into three further sub-categories:

- Emotional, long and disconnected 33/8
- Helpful and informative 18/7

Emotional, long and disconnected

The clients' view of the therapeutic process was rather fragmented. They depicted establishing a trustworthy relationship as a difficult enterprise. They listed several personal and organisational factors contributing to this: for example, their own attitudes, beliefs and expectations, their physical illnesses, the counsellors' or interpreters' ways of communicating with them, a mismatched interpreter or not being provided with the same interpreter for subsequent sessions, and uncomfortable settings. It also took a long time for the clients to get to know their service providers and efficiently utilize the services offered. Thus, they sometimes felt that the relationship was broken and confusing.

‘... there was a disconnection somewhere, that...he didn't understand. There, a question is asked, and you answer it, then another question is asked. Your mind was already confused and messed up. And you say ‘what is happening? Why do we come back again or why is it like this?’(Safiye-175)

Other reasons for some were having language difficulties and counsellors' being judgemental towards them. Perihan seemed to find ending the counselling as harsh with her feelings and expectations, indicating a need for a gentle closure.

‘I had to finish the course of therapy...But I didn't have any hope.
“That is how far I can help you.” he said.’(Perihan-192)

The points made above broadly resonate with the common experiences of asylum seekers and refugees. MIND (2009) noted that it is not the refugees who are abnormal, but rather the circumstances they found themselves in. Many factors contribute to their plight including traumatic situations in their country of origin and during their journey to the UK, the effects of UK government legislation, cultural and language barriers and tensions within families.

Helpful and informative

On the one hand the clients were frustrated but on the other hand they justified the obstacles that they encountered, realizing that resources were scarce. Overall, they rated their counselling experiences as positive, helpful and informative. Their main reasons for this were the opportunity of being able to talk and learn throughout. This made them feel

understood, helped and valued as a result. Some underlined the educative nature of the encounters, arguing that they had learnt a considerable amount from the counsellors.

‘...You lack information, and the counsellor informs you... you become more knowledgeable, then you start feeling better in yourself. Also, the counsellor changes your views...’(Ozay-7)

For the clients, it was inevitable that the triadic relationships took a long time to settle down, and required patience and perseverance. None of them were offered any long term therapeutic help that might have had a profound impact on their lives, although they still learned from it.

Theme B: Organisational and good practice issues

This theme relates to non-clinical dynamics that the clients described as influential factors for the triadic relationship.

Table 21 shows what the clients expected to see from the counsellors and interpreters in terms of professional and personal qualities which are presented in three main and eight sub-categories with one hundred and nine meaning units.

THEME B: Organisational and good practice issues		
Main categories	Sub-categories	Number of Meaning Units /Number of Participants
Expected qualities: Interpreters	Language competency	17/5
	Genuineness and empathy	15/8
	Specialization	14/4
	Being accountable	10/3
Expected qualities: Counsellors	Knowledge	12/7
	Interest	8/2
Other factors	Organizational issues	20/5
	Others	13/7

Table 21: Theme B (Clients): ‘Organisational and Good Practice issues’

Expected Qualities: Interpreters

The clients put emphasis on the reasons why interpreters should follow professional codes of conduct, how they should employ their linguistic skills in practice and why their personal characteristics mattered. The expected qualities the clients expected from the interpreters were as follows:

- Language competency 17/5
- Genuineness and empathy 15/8
- Specialisation 14/4
- Being accountable 10/3

Language competency

The linguistic skills of the interpreters elicited a considerable number of comments. This competency-related element involved skilful communication within the target and the source languages. For the participants, mental health interpreting was too risky for novice interpreters; some clients were asked by some interpreters about how to translate certain words, which diminished their trust in the process. Baz, for example, said that he was unable to talk about dreams, which distressed him because the interpreter could not interpret properly. Some clients found the accent of some interpreters irritating when the interpreter was not from Turkey but from a neighbouring country. This too undermined their confidence.

‘...their English wasn’t very well...They were trying to compensate their lack of competence...’ (Slimlady-80 &122)

Chen (2006) described interpretation as a ‘bilingual art’. It is of paramount importance for interpreters to have good linguistic, interpersonal and ethical decision-making skills (NCIHC, 2010). They are expected to work around intercultural awareness with both clients and service providers, to have a strong sense of duty, a high standard of linguistic proficiency with a large vocabulary and encyclopaedic knowledge, and to effectively understand the cultural, societal and linguistic changes both in the clients’ and the service providers’ culture (Xu, 2006; Zhang, 2011).

Genuineness and empathy

To the clients, being a professional and behaving professionally was one aspect, being a good person with empathy and a desire to help was another. Their responses suggest that by personal qualities they meant being genuine in their acts and feelings, showing empathy not only to the clients, but also to the counsellors. Interpreters were further expected to be skilful and flexible in sorting out problems that emerged during sessions and when the clients felt confused and deeply upset, motivating the clients. For example, Slimlady complained about her interpreter being too professional to the extent that she did not show any empathy. All clients described a good-natured interpreter as one with sincerity and good manners:

‘Good interpreter must be a trusted, friendly and a very polite person...’(Baz-221&223)

One interpreter cleverly observed some interpreters not appreciating silences during the encounters especially when they were providing conduit interpreting. Genuineness, honesty and flexibility are significant tenets for an effective therapeutic relationship, and it is not uncommon for clients to expect the same emotional and intellectual stance from the interpreters too.

Specialisation

The clients commented that they found sessions more satisfying when interpreters had specific knowledge and experience in mental health. They differentiated interpreting for mental health from interpreting, for instance, for engineering. They noted that as mental health is a vast and highly complex area, it was unlikely that interpreters would have in-depth knowledge about mental health conditions, therapeutic models and approaches, and the cultural concepts that describe them. Some clients explained that when they were provided with more experienced interpreters, they found it highly satisfactory. Martin reflected;

‘... my observation is that if the interpreter works subject-oriented, they perform better...become more helpful...[otherwise] whatever you say sound like a joke, laughable thing, to the interpreter. If they know their field, the patients and their concerns, they understand more.’ (Martin-18 &129)

The second reason that clients thought that interpreters needed further specialized training is that the interpreters were inevitably affected by the process and that this adversely affected their ability to interpret effectively. Safiye recalled one of the interpreter's reaction to her story during the session;

'He [used to] interpret in another field, totally unrelated to ours. He said that he [the interpreter] was psychologically impacted in this area [mental health]. Once, he stopped suddenly... because he felt the pain...' (Safiye-251)

This quote shows that the interpreter had transference or emphasised too much. Emillion (2011) noted that interpreters experience counter-transferential feelings but do not have the necessary skills to manage them. Some authors suggest that better trained and equipped interpreters provide reliable information for clinicians (Fatahi et al., 2005), led to better treatment adherence and improved attendance rates of patients (Stevens and Holland, 2008). Raval and Smith (2003) found that most difficulties that therapists encountered were due to a lack of appropriately trained interpreters, which led to inaccurate translation or a sense of the work being taken over by the interpreter.

Being accountable

The clients argued that interpreters, similar to other mental health professionals, should belong to a professional body so that they will be accountable for their practice. They drew attention to both personal and professional qualities, arguing that interpreters represent both the system and the clients. Therefore, they should observe certain codes of practice of their profession, and be coherent no matter what kind of clients they are interpreting for, practising safely and observing the boundaries. Some clients seem to be unsure about the background and practice of certain professionals, mixing the rules and their roles with those of interpreters. Safiye linked her concern with her perceptions about medical professionals.

'...we trust professionals...particularly doctors because of the oath they make, the Hippocratic Oath! This automatically makes us to trust them. You go into the highly sensitive and private matters, and you wonder if they [interpreters] keep their oath...' (Safiye-130)

In a study of the mental health needs of Turkish, Kurdish and Turkish-Cypriot men, a similar conclusion was reached that most participants did not seek help because they could not trust their GPs enough to disclose their problems (Derman, 2009).

Interpreters do not swear to anything akin to the Hippocratic Oath unless they operate in courts. Although there have been many improvements in the field, community interpreters lack robust training and professional recognition (Tribe with Sanders, 2003; Hwa-Froelich & Westby, 2003). Also, many interpreters do not belong to a regulatory body such as the ITI (Institute of Translators and Interpreters) which calls for the consideration of establishing a union (Holmgren, Sandergaard and Elklit, 2003).

Expected Qualities: Counsellors

This main category concerns the clients' views on how the counsellors should present themselves professionally and personally. These qualities include having knowledge and experience in the field, knowing what to do in certain situations and handling unexpected issues. These are summarized in two sub-categories:

- Knowledge 12/7
- Interest 8/2

Knowledge

The participants regarded counsellors as more confident than interpreters in employing their skills, arguing that their training and their membership of a professional body makes them more able and trustworthy. They observed the counsellors as being able to handle complex issues, even though they sometimes could not do much to change the situation. But sometimes being understood was enough:

‘He/she understood me about the problem that I went for.’(Martin-22)

Counsellors, particularly those working with diverse client groups should have extended knowledge of the clients and communities. Some therapists reflected on their experiences of being a foreigner and not speaking the language of other countries, which made them more considerate in their practices (Stevens and Holland, 2008).

Interest

The clients said that they were considerably influenced by the counsellors' genuine efforts and empathy to understand them. They were also aware that clinicians would not be able to understand every client. However, some counsellors were praised for their special efforts in understanding the client's framework and showing appreciation of the client's ability to survive. Perihan stated that she was not fully understood when she talked about spiritual matters. It did not seem to make any sense to the counsellor that she tried to seek further meaning in spirituality. She was pleased that the counsellor managed to work with her despite his limited insight into it, and that he was particularly curious about her coping strategies.

‘...He was asking me: ‘How have you been coping? Tell me so that I can tell my other clients! I told him that I believe in Allah, HE has been helping me and there is no another way to solve things.’(Perihan-155)

Munday (2009) reported the clinical psychologists' amazement at the resilience and strength that their clients presented. The psychologists in her study found that their experience led them to change their views about the human capacity for adversity, and about ways in which clients were sometimes negatively portrayed by the media and the system.

Other factors

This category explores how the participants and their relationships with the counsellors and the interpreters were significantly influenced by external factors. These factors include the lack of language services, unmatched interpreters, the limited time allocated and waiting lists. Moreover, responses revealed great concerns regarding how confidentiality was understood and assured. The issues are further explained in the following sub-categories:

- Organisational issues 20/5
- Others 13/4

Organisational issues

Issues that were related to accessing services, bookings, language and translation are highlighted. Some clients expressed their frustration at not being able to see a mental health professional when they needed to because of waiting lists, and of being unable to change their counsellor when they were not happy. Some felt that they were trapped or lost within the system. They were further distressed by being sent to various venues and being seen by different staff, which was confusing given the procedures and expectations that were imposed by different authorities. One participant metaphorically explained her situation:

‘You have experienced many break ups and fractions so far. You were already in emotional difficulties...You are thrown from one place to another like a tennis ball. You are looking at things...but, maybe, you are looking into an emptiness!’(Safiye-108)

Some felt that they were not genuinely listened to and that their points of view were dismissed; Baz mentioned unkept promises made by the practitioners, Perihan was constantly reminded that she had to learn the language:

‘...they tell me that ‘if you want it [the services], there is a lot to learn, go to a course...’But my head is not up to it, I cannot tolerate things. I am impatient, feel over the edges...’(Perihan-221)

Language match was also mentioned as an organisational impacting factor. Clients stated that it was common to be provided with an interpreter who was not from their country of origin and who was unable to speak their dialect. Some were concerned that a mismatched interpreter could lead to misdiagnosis or misinformation about them. Therefore, booking agencies must ensure that the interpreter matches the client’s need.

...agencies hiring them [interpreters], they must know that their English is [sufficient]...’(Roky-172)

A study carried out in Hackney in London found that language, and lack of information about the system in the UK and culturally appropriate services were the main barriers to seeking help (Derman, 2009, MIND, 2009, Department of Health, 2005). Talking therapies implemented by some Primary Care Trusts did not consider the cultural and stigma issues for the communities that they were intended to serve (MIND, 2009).

Others

This sub-category reports the participants' views on gender issues and other factors that they thought relevant to their experiences. Clients did not particularly talk about any concerns in relation to the gender of the interpreters and counsellors, partly due to being provided with interpreters of their own gender or an experienced interpreter of the opposite gender. Martin expressed his appreciation and satisfaction from working with an experienced female interpreter. Perihan and Safiye worked with several male counsellors, and their concerns seemed to be more about the counsellors' style rather their gender. But they added that the female counsellors and female interpreters were highly skilled in showing empathy:

‘‘Because he was a male and therefore he might judge me.’ I felt.

Women are better in understanding feelings...’ (Safiye-148)

Clients were asked if they had experienced anything that had hindered their relationship in the questionnaire. Although they did not mention any major factor, they felt that the physical appearance of the counsellor and conditions of the setting where the encounter took place worked against their perception of the counsellor. The clients were additionally asked to mark on a list the factors that affected their relationship with the interpreters. Nearly all of them found the interpreters to be confident and trustworthy in their attitudes towards clients and their professional stance, and, also found consistency in seeing the same interpreter to be influential. The factors which affected them the least were the interpreters' ethnic background and their political views in their answers.

Summary of the Clients data

The client data revealed an ambivalent picture in relation to the dynamics of the triadic therapeutic relationship. The clients described the process as sometimes helpful, always emotional, but also disconnected, biased and unfair. They suggested that although they felt relieved when they saw the interpreter in the room, believing that they would be able to talk about their problems, disclosing or sharing their intimate experiences and feelings with two strangers was unexpectedly discomforting.

The clients seemed to be apprehensive about the presence of interpreters as most interpreters came from the same community. Although this could possibly be overcome by short briefing sessions, this did not happen. They struggled with their feelings of fear and

stigma about the interpreters' potential reactions and confidentiality. Clients were also aware of their own biases and feelings in relation to the counselling enterprise and the counsellors, realising that some of their encounters failed due to their own thought processes or ill-health. The clients expected to trust counsellors, putting them in a position of an authority possessing the knowledge and power. They therefore liked being offered advice and guidance.

Their stories also revealed that clients were not passive recipients of the services they were offered. They checked whether the interpreter or counsellor understood them by observing their facial expressions, bodily movements and gestures as well as the verbal responses of both the counsellors and the interpreters.

Overall, the clients had positive and helpful counselling experiences and were grateful that they could receive emotional support with the aid of an interpreter despite their anxiety about confidentiality. They clearly needed to be in the therapeutic relationship long enough to establish trust and a sound working alliance within the triad.

CHAPTER 7: DISCUSSION

Introduction

This chapter reviews the findings from the study of the impact of interpreters on triadic therapeutic relationships and discusses how they relate to current knowledge about this process. It recaps the aims of the research with a short introduction and re-states all the themes and categories elicited under the overarching or super-ordinating themes. The limits of the study and difficulties encountered are discussed followed by the recommendations made by the interpreters, counsellors and clients throughout. The chapter ends with a conclusion.

The results of the study have confirmed that triadic therapeutic work through an interpreter is dynamic, complex, problem provoking as well as rewarding and positive (see Miller et al., 2005; Munday, 2009; Tribe & Thompson, 2009; Saxthorp & Christiansen, 1991). This dynamic process reveals that the complexity of the process and the challenges faced by the interpreters and counsellors are reflected in each member's feelings, expectations and actions.

The dynamics of therapeutic work with refugees and non-English speaking clients through interpreters has been investigated in various ways. Most of the previous research has explored the topic from the clients', counsellors' or interpreters' points of view or from any two parties in the triad. This research aimed to fill this gap by giving voice to all members of the triad, the client, the counsellor and the interpreter. In this pursuit, the main questions asked included:

- What are the main challenges for counsellors in helping non-English speaking clients?
- To what extent do non- English speaking clients feel helped in counselling when an interpreter is present?
- How do interpreters cope with the emotional demands of working with counsellors and non-English speaking clients?
- How does each member of the counsellor, client, and interpreter triad cope when difficulties are encountered?

Overall, this study has generated three super-ordinating themes, eight themes, thirty-three main categories, ninety-five sub-categories and thirteen further sub-categories with one

thousand six-hundred and seventy meaning units across the data gathered from the three sets of data. Super-ordinating themes will be explained in the following section.

An integration of themes

The research was conducted in three parts. Data was collected from a group of interpreters, counsellors and clients, and analysed within each group. Themes and categories were developed for each group using Thematic Analysis, through which common opinions and concerns have been collated. This section offers a cross analysis of the three groups that generated three over-arching themes. These three overarching themes are discussed under their relevant subheadings.

The results of all the analyses have shown that there are more similarities than differences across the participant groups in terms of their perceptions of the processes, common concerns, expectations and of their needs. The following overarching themes address these.



Roller Coaster

This theme summarises the tidal nature of both the therapeutic and the interpreting processes. The metaphor of roller coaster was used to symbolise the ups and downs of the process: there were times when the participants felt relieved, excited and moved and times when they felt alienated, sad and fearful as in the twists and turns of the ride. Participants summarised the process as broken, repetitive, emotional, biased and long; but there was a consensus that the process was overall positive, informative and helpful. All made a positive comment when asked about their overall evaluation of the whole process, but many were negative when they were asked to focus specifically on their last counselling session with an interpreter. However, this did not change their overall evaluation of the processes.

Participants' comments about the broken, repetitive and distant nature of the counselling process echo the research literature that suggests that offering emotional help through a

third person hinders the establishment of a satisfactory relationships in a triad. Similar findings were reported by Payne, Ciclitira, Starr, Marzano and Brunswick (2015) that triadic relationships lack the relational experience, and hence may seem like a mechanized process (Miller et al., 2005). The challenges that were experienced suggest that the contexts where the therapeutic encounters took place were not regarded as supportive and inclusive by the participants for different reasons. Those reasons seemed to be the outcomes of various organisational, cultural and personal constraints.

This study confirms that the triadic relationship had been a significant dynamic for all, and the analyses point to a somewhat dilemma driven process. The dilemmas seem to be both the causes of and the results of many concerns. The whole process was described as being unexpected and complex in which the roles and the rules constantly changed.

In the next sections, I will evaluate the tidal nature of the relationships in terms of both the positive and the negative aspects through the lenses of the dilemmas that participants experienced. These dilemmas capture the essence of the emotional, intellectual and social aspects of their experiences. The order of the dilemmas will again be in the order of the recruitment.

Interpreter dilemmas

The interpreters experienced the most role conflicts and hence emotional and professional ambivalence. They were frustrated by the loosely defined contextual rules and the arbitrarily assumed roles created for them. The main role conflicts that they were drawn into include the clients' efforts to get close to the interpreter; the clients' disclosure of unexpected information; and the service providers' unnecessary remarks about clients. Hsieh (2004) explains that the fact that interpreters are bound by a code of ethics and institutional policies may give rise to conflicts at times of varying role performances, their self-perceived roles and others' role expectations.

Some interpreters were clearly concerned about descending into a robotic emotional state in the face of human suffering. Some clients made disclosures to them in and outside of the sessions, and likewise, inappropriate comments about the clients were sometimes shared by the service providers. They were left with the questions of 'Should I interpret this?' or 'How' and 'When' should I do it?' The results reveal that the interpreters were unable to vocalize their feelings and thoughts effectively during and after these incidents. They lived

with the fear of being accused of malpractice and losing their self-esteem. Some clients shared most of their story outside the session, asking the interpreter to sum it up inside. This could be a major concern if the interpreter is not experienced.

Interpreters in this study explained that they were left in suspended and ambiguous states where they had to act like advocates rather than conduits. It was not their initial intention to do so, but they reacted to the service providers' actions or unwillingness to deal with the situation. The interpreter feared that if they complained to the authorities about the service providers, this could result in further tension for all involved, including the client.

The mode of interpreting was another source of dilemma. The Conduit mode in which the interpreter acts like a translation machine (Hsieh, 2004) did not create a social space for interactions, forcing further communication to take place outside the counselling setting (Tribe & Morrissey, 2004). Triadic therapeutic encounters with culturally different clients would necessitate conveying emotions and culturally ingrained and value-laden concepts. Furthermore, human interaction or the norms of courtesy may require the interpreter to share their condolences when necessary. Some clients might have wondered why the interpreter offered no expression of sympathy, which hindered the establishment of trust, and made the client suspicious of their understanding.

In addition to the conduit mode's unsuitability for mental health interpreting, the literature documents that it also fails to account for issues such as social class and belief systems (Kaufert & Putsch, 1997), and that ethical codes based on the conduit model can be misleading (Solomon, 1997). The expansion of the interpreter roles beyond the Conduit model has long been debated and is far from being settled as different settings have their own rules and guidelines. The research literature acknowledges contextual differences that would lead to varying practices, assumptions and regulations: for example, Maddux (2010) describes forensic settings in which interpreters use the third person language interpreting instead of the first person, when working with cases of extreme violence and acts of sexual deviancy.

Another dilemma originated from the fact that the interpreter and the client came from the same cultural background. The interpreters felt for their clients regardless of their country of origin, especially in situations where there was an unfairness. Their empathy seemed to be strong when they observed their fellow countrymen and women suffering as in the case of a participant who had to tell the healthcare staff to stop shouting at the patient, which

violated her role definition. As Dysart-Gale (2005) notes, practice related conditions can push interpreters into ethical conflicts.

An interpreter can sometimes be regarded by some clients as a source of comfort and trust, but this is likely to lead to emotional and professional conflicts in interpreters, especially in small or emerging communities. This human tendency may lead to a violation of the professional oath, which is known as '*Collusive Process*' (Antinucci, 2004) or '*Nostalgic Collusion*' (Akhtar, 2006). A common language and cultural identity may come into play and become part of a collusive process between clients and therapists (Costa and Dewaele, 2012). Some participants spoke of clients who refused to work with certain interpreters due to the shared negative cultural experiences.

The interpreters reported further dilemmas as to how they could overcome their feelings and tolerate silences that occurred during sessions. Interpreters and counsellors repeatedly elaborated on their difficulty of dealing with sensitive and unexpected revelations from the clients. These findings concur other research reporting that interpreters and practitioners are affected by the content of traumatic client material (Salihovic, 2008; Century et al., 2007, and Miller et al., 2005. Talbot, Pahleva and Boyles (2015) add that as part of working through sensitive material, silences would be inevitable, familiar territory for counsellors but which may overwhelm interpreters who are not trained to deal with silence in psychotherapeutic terms.

The interpreters reported burnout, shock, disbelief, confusion, and feelings of being deskilled. Some accounts show that they went through varying traumatic feelings upon hearing about prodigious family losses. To some interpreters, this meant more because of its resemblance to their own experiences, which is caused by overidentification with the clients (Butler, 2008). One participant shared that feeling too much for the client caused further catharsis in the client, bursting into tears; another interpreter similarly shared that he or she could not bear to see the client's agony and helplessness. Some vividly reported their feelings of not being able to rid themselves of the client's story, sometimes being unable to sleep, to relax or to ask for support, as well as being fearful and tearful. This suggests 'secondary trauma' (Salihovic, 2008; Talbot, Pahlevan and Boyles, 2015), and sufferers require training, supervision and support to overcome the negative effects.

Regarding the research question of how the interpreters coped with the demands of their jobs, it can be concluded that although they practiced their linguistic, emotional and social

skills as best they could, the interpreters struggled in achieving a balanced stance. Some took time out to heal, some managed to utilize other resources the most important of which was to have a supportive family around them.

In terms of coping with the ongoing difficulties and the complexity of the work or the clients, they felt inadequate. Their main frustration however came from their experiences of working with staff who were not effectively trained in working with interpreters or with certain client groups needing interpreters.

Finally, the analyses show that some of the factors that helped interpreters to manage the process involved having passion and maturity, eagerness to learn and flexibility to adapt. The main obstacles to processing the emotional ordeal that they went through were lack of appreciation and support.

Counsellor dilemmas

The results show that the triadic therapeutic and interpreting processes provoked dilemmas for the counsellors too. One of the dilemmas was the use of children as interpreters. One counsellor shared that for a family who came from a war-torn country, an interpreter who was not known to the client could evoke strong mistrust in the client, therefore, depending on the context, children might be more trustworthy interpreters. Although the professional codes of practices (BPS, 2008; BACP, 2009) suggest that it is unethical to use children as a bridge, given the sensitive nature of the encounter, some practitioners argue that if the family members feel more trusting and better served, it may prove beneficial for them. The literature does not exclude these views: for example, Turton, De Maio and Lane (2003) argue that it might be good to have someone who is not linked to the family for some topics, while in other cases, it might be crucial to have someone who knows the family.

Another dilemma concerned the extra demands that were put on the counsellors. They explained that this significantly distracted them from their main role. Munday (2009) reported similar findings that clinical psychologists had to deal with some non-clinical duties, often feeling that they had to fight for and advocate for their refugee clients. These tasks sometimes enable the client to move on, by removing obstacles that prevent clients' use of talking therapies. Being occupied by activities that do not fit with their therapeutic model was a cause for concern. It also resonates with the researcher's experience as an IAPT mental health practitioner in the NHS where their work was halted by non-

therapeutic or administrative tasks such as filling out forms and phoning courts to adjourn client cases. Although significant for clients, Delgado et al. (2016) argued, they did not necessarily lead to better therapeutic outcomes.

A subtler dilemma was related to the imbalanced nature of the triadic relationships especially when the client became closer to the interpreter. This control-related matter was of great importance for some therapists. The discomfort lies in the fact that interpreters might become more powerful than counsellors depending on the topics they are working on. One participant was adamant in making sure that the interpreter knew the rule from the beginning that the ultimate authority belonged to the therapist. Some clinical psychologists similarly reported the dilemma of feeling powerful and helpless at the same time when working with refugee clients (Munday, 2009). Although mental health workers anticipate that clients may seek further support or comfort in interpreters, they felt that their confidence was undermined, and thus they could view interpreters as 'obstacles' (Miller et al., 2005) or a 'necessary nuisance' (Tribe and Thompson, 2009).

The dilemma of holding much knowledge and feeling powerful then suddenly becoming helpless and inconfident deeply challenged their sense of power and helpfulness. Counsellors also experienced a culture-shock when meeting with unknown situations, stories and surprises. Al-Roubaiy (2013) found that mental health professionals were reluctant to work with refugees as they were challenged by the impact of pre-migration trauma on clients. But, none of the counsellors in this study stated that they would not prefer to work with this clientele, rather they embraced the challenge. One of the explanations of this finding can be the fact that the counsellors' group was highly diverse.

Although not shared by all within the counsellors group, one counsellor and some in the interpreters group underlined the impact of racial issues on their practice. Helms (1993) noted that therapists might not be willing to attend to racial and ethnic factors in therapy due to a lack of awareness of racism and how it might impact on their clients but also their unreadiness to explore their White racial identity development (see Tuckwell, 2002). Some participants touched on the rigidity of Western thinking when working with therapeutically diverse clients. Some related certain practices to what had happened in the past, indicating the impact of shame and the fear of being called 'racist'. This was another source of dilemma when working with culturally different clients and with interpreters. The literature indicates some fears in exploring one's own identity in the case of Whiteness or White privilege (Malik, 1996; McIntosh, 1998; Tuckwell, 2002). These include the potential loss

of “status, money, respect, purpose, life plans, family, friends, pleasure, institutional support and sense of identity” (McIntosh, 2009; p. 7). In terms of affective responses to these issues, Leach, Iyer and Pedersen (2006) argued that anger, defensiveness and disgust could be a reaction to the injustice of privilege and oppression.

It can be concluded that based on the findings of this study, counsellors are not supported towards these silent but highly influential societal issues. In combating these, as some clients and authors suggest that therapists should be proactively working towards empowering their clients (Chantler, 2005), sometimes by challenging their therapeutic assumptions of being content whatever they have and forcing them to accept the unfairness in the society (Ancis & Szymanski, 2001; Iyer, Leach, & Crosby, 2003). However, dealing with and working through these challenges may not be an easy ride for some as there is a lot of stigma attached to it. It is likely that anyone who is willing to take action could become overwhelmed by the magnitude of the subtle difficulties (Feagin & McKinney, 2003). It, therefore, calls for well thought training programmes and supervisors who could take the racial issues on board with their supervisees.

In terms of the research question of what the main challenges were for the counsellors in helping non-English speaking clients, it is found that the difficulties were experienced in the areas of language and culture; working through interpretation and translation, and embracing unknowns, unexpected events and the complexity of their work.

Another research question concerned how each member of the triad coped when difficulties were encountered? The results suggest that everyone used their own resources to come to terms with the problem they encountered, that things were not always handled well and that caused resentment about the system. At best, clients were assigned to a better service/department, interpreters were offered ‘one off’ debriefing sessions and the counsellors had suitable supervisors with whom they could share the complexity of their experiences.

Client dilemmas

The dilemmas that the clients experienced were mostly related to trust issues. Trust was the encompassing theme throughout the study. For that reason, it will be discussed in detail in the ‘Trust for all from all’ section.

Positive aspects of the roller coaster process

Being on a roller coaster provided participants with the feelings of excitement about the unknown routes of the process with the help of other two, and hence some satisfaction. Participants overall found the process beneficial and informative, regarding the challenges as part of their personal development.

Enhancing growth

The counsellors considered gaining knowledge and experience, and becoming mature and creative as growth. The results show that working in triads does not always lead to adversely challenging outcomes. It can be constructive when utilized appropriately and wisely. Robertson (2014) found three-way comradery to be a significant positive aspect of working within this framework. Some authors mentioned a beneficial aspect of this work is that therapists have more time to think and reflect (Miller et al., 2005), interpreters having time to configure the best interpretation, and of the clients observing others and understanding how they work (Talbot, Pahlevan and Boyles, 2015).

Mirdal et al. (2011) added that the therapeutic relationship itself was the main curative factor in the triadic process. Linley and Joseph (2007, p.25) described this phenomenon as ‘vicarious post-traumatic growth’, that is a positive psychological change in an individual following exposure to trauma. Perhaps this feeling was the key to the participants’ overall positive attitude in this research.

Although some interpreters distanced themselves from their frustration with the system and the staff, this maybe helpful in drawing boundaries between themselves and clients as well as other professionals. Clients learned more about the life, which is a permanent gain. The clients often, despite their lack of literacy and knowledge of the health system, listened to their instincts and reflected on their thoughts and feelings to guide them. White and Epston (1990) term this ‘insider’ knowledge, that people inherently know what life means for them and therefore can cope with their problems (in McLeod, 2013). McLeod (2013) introduced the concept of ‘wisdom’ that exists in every culture. Considering clients’ knowledge and expectations can make significant differences and may result in better therapeutic outcomes. One client stated that her counsellor could not understand how she had coped with all the hardship that she had gone through. The counsellor did not recognise or acknowledge the power of her beliefs.

Self-esteem booster

The participants' experiences also suggest that the whole process improved their emotional and psychological well-being. Some counsellors mentioned their increased self-esteem and self-confidence because of managing their work with interpreters well. Their perspectives were widened as they have learnt a lot about themselves, assessed their own level of knowledge and skills. They have learnt much about procedures and policies in the UK, and in some cases, abroad. These outcomes concur with some are in support of the literature: Raval (1996) reported that therapists found it easier to talk about racism and cultural differences with their clients when the interpreter was present and working as a team. Bowker and Richards (2004) argued that working with bilingual or non-English speaking clients was rewarding in terms of creating a different language, new ways of communication with new meanings in relationships. Munday (2009) concluded that her psychologist participants regarded their experiences of working in triads with an interpreter as enlightening, leading to a better understanding of cultural, racial, societal and political issues. Splevins et al. (2010) acknowledged that interpreters can positively benefit from the process by learning how to cope with their own stress and in managing both private and work life. Schweitzer, Wyk van and Murray (2015) further elaborated on the positive effects of therapeutic experiences with refugee clients, reporting increased contemplation of existential issues developed as a result of trauma and torture related work.

Another positive point made by the interpreters was the joy of doing their jobs. One interpreter said that interpreting was her dream job, and her reason for that was being able to talk and share others' concerns. Although not discussed in detail as it was towards the end of the interview, it can be speculated that this could have been due to his or her loneliness or related to their initial motivation for work. Nevertheless, regarding the participant's point, there was no evidence that he or she socialized with clients further apart from booked sessions.

The analyses also suggest that satisfaction was not solely based on helping. Interpreting jobs provided interpreters with opportunities to be with highly specialized professionals. There is much learning through observing the practices, attitudes and communication styles of highly respected professionals such as judges, surgeons, academics and politicians, which can be a source of intellectual satisfaction and aspiration. Interpreters, like other practitioners, experience and create a variety of means of acculturation through these socialization processes, by which they observe, learn, complain, share, teach and show.

These findings also answer one of the sub-research questions of why some individuals enter or stay in the sector. Grant (2009) found that the core element of the interpreters' experience was relating to clients, therapists and organisational systems. They seemed to experience the feeling of connectedness through the work of collaboration and facilitation, and of times of isolation.

Although research has not revealed much about the interpreters' motivation for work apart from wanting to help and earning additional income, the main motivation for people entering the counselling and psychotherapy field has been well documented. Caring and making contribution towards improving social and emotional lives of people and altruism are the common motives for counsellors and therapists (Wheeler, 2006; Barnett, 2007; Beatty, 2012). The research also notes that individuals are attracted to the counselling and psychotherapy profession as they themselves were wounded by their experiences, and that the work helps with their self-development (Beatty, 2012).

The experience of being hurt may apply to the interpreters too. Some interpreters have gone through similar experiences as their clients such as leaving their countries, being subject to political, social and religious persecution, being a victim of torture and rape, suffering from a broken family and the loss of loved ones. Their work involves helping others in turn promoting their own healing.

For the clients, learning was the positive outcome of the process, rating their overall experience as informative. They have learnt not only about their health or ill health and new ways of tackling their problems, but also about what counselling entails and how counsellors work. This process, although frustrating and painful, helped clients settle in a better and a more integrated way into society through a guided socialization process. In addition to the fact that counsellors guide and empower clients, some authors argue that interpreters can be excellent tools for clients in terms of providing a good working model (Tribe & Morrissey, 2004). They can better understand a society through interpreters who have already integrated and who are contributing to society in their new country. Hence some clients want to further engage in conversation with interpreters. They tend to ask about how they, the interpreters, coped with their hardship, how their families settled in, how they improved themselves and which authorities they turned to for help.

Related to all participants' experiences of learning and understanding a new language and learning about a new culture, it can be argued that this was a positive and moving outcome

for them. Dewaele (2016), for example, conclude that learning a foreign language can make people more creative, more openminded, more emotionally stable, more sociable, more likely to enjoy foreign language classes, better equipped to learn new languages and less anxious in communication (p.12). Cook (2002) similarly concluded that bilingualism and multiculturalism resulted in multicompetences.

In summary, ongoing learning, becoming wiser and increasing self-esteem were the common positive experiences that the participants shared. They were expressed in a dichotomous way; on one hand, some witnessed a wrong doing, intervened, felt guilty and stopped it, on the other hand, some witnessed highly regarded practices, loved it, and further modelled it. In the end, they all have learnt.

Trust for all from all

Trust was a consistent encompassing theme and the underlying core element across the participant groups. This theme can be best summarized as a 'strong need to trust and be trusted', illustrated in Figure 2. The counsellors expected the clients, the interpreters and the system to trust them as reliable and competent practitioners; the interpreters expected the clients, the counsellors and the system to trust them and recognize their contribution. The clients expected to be trusted by the interpreters, the counsellors and the system and be respected that they had genuine reasons to be here and deserved to be heard.

However, the results show that none of them seemed to ensure the trust and bonding as they had hoped to.

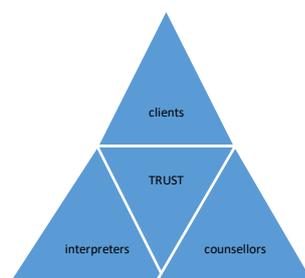


Figure 2: Trust as a core of the relational dynamics

Some clients and interpreters explained that they did not find the counsellors genuine and engaging and that their demands were not taken seriously. Similarly, some counsellors found some interpreters incompetent and over-involved.

Trust had further significance for the clients; they were not comfortable with the fact that they lacked knowledge and linguistic competencies, hence found it difficult to trust. They were unhappy about being afraid of and uncertain about their future. They felt that they did not have enough skills to determine if they could and should continue with the sessions when they were unhappy, and therefore were living in an ambiguity and with the fear of not being given another opportunity with another counsellor, which Mudadi-Billing and Eschoe (2011) called ‘fear of losing contact completely’.

The analyses reveal that the presence of the third person had an inevitable impact on the process. The literature similarly notes the mystery and distrust in mediated communications (Century et al., 2007; Engstrom, Roth and Hollis, 2010). These dynamics seemed to be easily changed by a variety of factors, of which many were not necessarily clear and logical to all. The process was altered depending on where the interpreter came from, how the interpreters presented themselves, and how professional, genuine and sensible they were. When the interpreters were not empathetic and lacked good linguistic skills, the clients and counsellors could not engage with each other, which evoked distrust.

Some clients claimed that poor interpretation could alienate them. Perhaps as an unconscious strategy, the results show that clients excelled in reading the non-verbal clues of others. Clients checked whether they were being understood by looking at the reactions of the other person. They were alert to being asked inappropriate questions, nodding of heads unnecessarily or mismatching remarks or comments being made. Some clients were wary of the counsellors’ approach, their level of education, spirituality, sexuality, the tidiness of the setting, eye contact and dress-codes. These suggest that clients are active recipients of the triadic process rather than passive users of the services. Language was everything for the clients: if that was not accurate, they felt lost. Using their intuition, inner knowledge and their own means of checking the reliability and genuineness of the interpreter and the counsellor was their guide.

Matters were not straightforward for the interpreters either. The results show that interpreters struggled in working with some service providers because of their lack of understanding of the triadic framework. Some service providers became suspicious about the interpreters’ discourse. The counsellors described their experience regarding language, translation and culture as ‘*Lost in Translation*’ in that they were unsure about the true and faithful interpretation of what was said, and apprehensive about the interpreter’s slant.

Being unsure about the other party's understanding and the feeling that clients missed significant parts of the discourse were remarked on as major concerns.

Stigma related to mental health adversely affected clients' willingness to share their worries. The clients shared their feelings of shame about needing an interpreter as they were unable to speak the language of the host country, and the necessity of having a stranger to help them. They explained that although they did not mind much, they preferred female interpreters as they felt that women could understand them better. Minas, Stankovska and Ziguras (2001) argued that stigma could have a profound impact on clients coming from ethnic minority backgrounds as they tend to be small and closely knit. Becher and Wieling (2014) argued that the triadic work with refugee clients was influenced by the culture of all involved and power-related dynamics.

Symons (2012) elaborated on power imbalances in therapeutic settings and contextual factors that deterred clients complaining of a harmful practice to the BACP. She noted vulnerable aspects of clients such as well-being or ill-being and the complex interaction of experiences as personal contexts. These personal contexts were putting clients in a vulnerable position in which they may not be able to express themselves fully. This study confirms that the interpreting context added another dimension to the situational and personal contexts that affected the clients' uptake of the services. The findings of this research show that some clients did not feel empowered and that, some were prevented from taking the direction they wanted to such as leaving therapy, changing their counsellors or even talking about the subject that they wanted to.

Apart from the social and political difficulties that the clients experienced, the clients' physical health and its impact on the therapeutic relationship were also observed. This research was carried out mainly with Turkish and Kurdish-speaking clients, and although their physical health was not investigated, they all linked their mental health difficulties with other ongoing medical problems. Research done by an organisation providing counselling services to Kurdish and Turkish communities in London, showed that mental health problems were common in people who flee their homes; that they suffered from depression, diabetes, cholesterol and bowel problems; that many women experienced discrimination, verbal and physical abuse, that nearly all businesses had experienced crime and the police were unhelpful; and that media reporting did not make things easier but increased the pressure on them (Derman Report, 2009; Cinar, 2013). McCormack (2005)

added that these circumstances did not provide perfect conditions for them to learn new skills.

Dynamics are so complex that counsellors may not be aware of them for cultural and language reasons. One counsellor described it as a '*Blind Process*' in which no one knows who will be coming in, what they will be bringing and how they will be reacting to each other. Some clients refused to work with an interpreter who belongs to a political party that oppresses certain groups of people; or who was from their village, and who therefore know much about the background of the client, or simply was from the same faith and ethnic group. There are fears that interpreters may be spies for the asylum-seeking individuals living abroad. It seems that it is a delicate balance in that any small move can become a significant concern; Zimanyi (2009), for example, noted that some clients might perceive the note taking practice of an interpreter as threatening. Talbot, Pahlevan and Boyles (2015) argued that the uneasiness of these clients was mostly caused by their past and their current experiences such as being provided with untrained interpreters or having no interpreter at all, and the ways in which they were treated by UK Immigration officers. Many of these clients continue to experience trauma long after the origins of traumatic situations are no longer present; for example, Al-Roubaiy (2013) reported that Iraqi refugee men described their experiences in terms of hardship and trauma as worse in Sweden than what they experienced in war-torn Iraq, and that one participant summarized it as 'dying many times but not killed in Sweden!'

All participants were concerned about wider societal and political affairs that had a detrimental impact on their trust. They pointed out some imbalances in the exerted power, and some subtle racial attitudes: for example, clients and interpreters expressed their experiences of their voices and needs being ignored and even discriminated against. One client described her experience with an array of appointments and interventions as being '*a tennis ball*' being thrown from one staff member to the other, emphasizing her powerlessness. The same client depicted her helplessness metaphorically, using a Turkish proverb ('Asking for help from a snake when fallen into the sea. '), equivalent to the English proverb '*Beggars can't be choosers*'.

Some counsellors similarly expressed concerns about the subtle patterns of practice and governance in relation to racial issues that they felt unacceptable. One counsellor said that the health system was not diverse and inclusive enough, carrying racial tendencies. She argued that the system or the policy makers were not ready to hear from this clientele about

their complaints. This attitude was reflected in the practices where interpreters are not provided for clients or who are not supported throughout the process. The counsellor described this deep-seated and longstanding debate as '*hot potatoes*' that burns whoever holds it.

The literature shows that one of the main reasons culturally different clients leave therapy is because they experience the dominant culture counsellor as biased and value-bound (Sue & Sue, 1999; Sue, 1981). To Mahtani (2003) it was institutional racism working to maintain the status quo of the institutions. Green, Bradby, Chan, Lee and Eldridge (2002) highlight that poor communication makes the system vulnerable to a charge of institutional racism. This occurs not only through overt racist views, but through lack of provision of much needed services. Munday (2009) reported the discomfort felt by clinical psychologists who realized the system as discriminated against certain groups of people. Symons (2012) underlined subtle power dynamics in therapeutic settings giving power to the therapist; Rennie (1994) termed this as the 'silencing effect of the power imbalance'.

This imbalance may also appear to clients who see the service provider and the interpreter as being on the side against them. The counsellor and interpreter together upset the balance of power for the client. This can potentially hinder clients' adherence to the treatment, the interpreter's effectiveness and the therapist's engagement with both. Clients who lack language competency in English may feel discriminated against by the two when they were not understood, and the trust was not established well enough. Chantler (2005) controversially noted that dominant therapeutic approaches favour male oriented, middle class and independent life, and this makes things easier for certain people to access and continue with counselling if they are in good health, do not have child-care responsibilities, are safe from violence and abuse, are materially well-off and mobile (p. 252).

I need as much as you need

This overarching theme summarizes the needs and the support that were aired by all participants across the data sets. This section includes further reflections on the participants' points. First, the interpreters', then counsellors' and finally clients' needs and expectations will be detailed.

Interpreters' needs

This research confirms that interpreters were neither trained adequately nor offered enough support, that they needed well-thought out training and supervision, and that they were subject to low professional recognition. It seems that ignoring the interpreters' presence or dismissing their contribution is a trend within the sector and this undermines the interpreters' self-esteem and confidence. One of the counsellors shared his observation that several interpreters he worked with were not happy about their work, but nevertheless wished to be trained as counsellors. Grant (2009) concluded that interpreters needed support and should be validated for their work as they have access to the client's world and at the same time they carry the risk of alienation produced by knowing both cultures but belonging to neither.

The results show that interpreters were keen on being equipped with the right competencies. Their willingness to undergo training and supervision were reflected in their desire to gain improved professional recognition which was an important focus throughout. In terms of competencies, interpreters need well-established and updated linguistic skills, not only in their second language but also in their mother tongue because clients may not be competent language users, having have accents and dialects.

The interpreter's personality was also found to be significant. The interpreters explained that their relationships with the counsellors produced positive outcomes if they were regarded as team members or experts in language and cultural issues. But many factors hindered this. Doherty, MacIntyre and Wyne (2010) listed similar challenges in mental health interpreting as establishing rapport between the client and the mental health professional, displaying sensitivity, taking a non-judgemental stance, believing the clients, maintaining confidentiality and setting effective boundaries (p. 39). Anderson (2012) extended this, arguing that an interpreter who was proficient in language but who lacked psychological maturity and self-awareness would not be ideal for the job.

In terms of clients' feelings, this study confirms that some clients were not happy about requiring linguistic help, finding it humiliating. Interpreters therefore should recognize the clients' feelings of shame. They can soothe these feelings by understanding the dynamics inherent in the process and by acting as culture brokers (Tribe, 1998a; D'Ardenne et al., 2007) to reassure the client and inform the counsellor. Interpreters are expected to be

familiar with their mode of interpreting or working practices, and adapting them to the context in which they work.

Interpreters were expected to understand the basic terms and concepts used in the field of mental health, the common dynamics of the triadic framework and common dilemmas inherent in the interpreting process. They must recognize their impact on relationships and on the psychology of the client. Interpreters have the potential to both decrease and increase the disclosures made by both the client and the counsellor. Hence working within boundaries is of paramount importance.

The interpreters should also be able to look after themselves. Anderson (2012) argued that interpreters should understand themselves as well as other members of the triad, particularly the development of the personhood of the interpreter. This would enhance their coping mechanisms in complex situations. Their own 'emotional baggage' and 'emotional unpreparedness' were reported in another study as impacting factors on their well-being (D'Ardenne et al., 2007). Leaving them without support may have further implications for the sector such as losing them, missing important client data and devaluing the practitioners' input. Due to a lack of understanding of how to manage and recognise the identification process and counter-transference feelings (Brown & Stobart, 2008), Butler (2008) contended that interpreters were more vulnerable to identification with clients than therapists. The research reported that, like therapists, interpreters might become an object of transference, projection, displacement or triangulation. However, unlike the therapist, they might not have the theoretical framework to make sense of what happens to them.

Interpreters can be subjected to transference feelings that are of a political nature. It was reported to the researcher in personal communication that some clients and some participants made political assumptions and statements that could be classified as harassment of the interpreters' culture or identity. These sarcastic, intimidating and politically-motivated comments could not be confidently handled by all interpreters. Also, clients tend to tell their highly confidential stories to interpreters outside the consulting rooms.

Zimanyi (2009) acknowledged the distinction between the therapeutic environment and the logistical or specialised interpreting context where the interpreters' psychological safety becomes more of a concern. Research has asserted that these can be overcome through peer support groups, practical coping strategies (Butler, 2008; Miller et al., 2005) supportive

family and trustworthy social relationships. The use of pre-and post-encounter sessions for mental health interpreters are suggested (D'Ardenne et al., 2007; Zimanyi, 2009). Pre-encounter work is similar to a pre-session where the interpreter and mental health professional go through the ground rules, boundaries, safety issues, case-related information, and the interpreters' working style and so forth. And post-counter sessions should be offered to check the interpreters' thoughts, feelings and needs. However, she found that there was some disagreement between the interpreters' and the mental health professionals' view of post-consultation support in her research. Practitioners regarded this session in practical terms while the interpreters' expectations were more on the side of receiving psychological help. The findings of the current study are in line with Zimanyi (2009) that the interpreters wished to have a follow-up that calmed down their emotions.

Having a supportive family around the interpreters was helpful in alleviating their exhaustion and in uplifting their low mood as well as listening to music and crying. Zimanyi (2009) reported similar interpreter self-help techniques but further suggested peer support and interpreter gatherings as ongoing support, and a telephone helpline to talk to their colleagues as part of the service provision. Some counsellors argued that interpreters should communicate with each other more and create a space for discussions as research reiterates that the interpreter's voice has been absent from emerging discourses in health and social care professions (Grant, 2009). Costa (2011) suggested use of Skype in providing low-cost support to interpreters both nationally and internationally.

The results also show that the interpreters who were affected most by the process were the ones who stated that they desperately required training and support. For example, one participant revealed that he or she was slapped by a patient, which was shocking for them. This suggests that interpreters should be informed about the clients' or patients' mental health or any significant health conditions before the sessions start. As there were no structured or well-prepared support arrangements for them, they exhausted their own resources, causing burnout.

Counsellors' needs

All participants shared the view that counsellors should have a sound knowledge and experience of work with other cultures, race and languages. One of the suggestions made was that practitioners should have the experience of living within the communities that they would be working with, carrying out a mini ethnographic research themselves.

Although this may not be practical in a real world, wanting to know about the communities that would be worked with is a must.

Some practices have tried different ways of overcoming the difficulties of working with interpreters; for example, in some practices, interpreters are employed as part of care teams and in some countries interpreters are chosen from the local paraprofessionals who have the local/indigenous cultural insights as well as the languages. As suggested by Tribe (1998a), interpreters are used as cultural consultants, and are expected to monitor clients' behavioural gestures and thought processes. Emilion (2011) reflected on the clinical aspect of working with interpreters within a team, arguing that the process was disconnected. Mirdal et al. (2011) similarly concluded that the triadic relationship itself might cause difficulties in establishing trust. The difficulty lies when the therapist is not experienced and is therefore unaware of the effects of the interpreter on the therapeutic relationship.

Counsellors were expected to observe the professional codes of conduct, be competent in their assessment, have excellent listening skills in both hearing the verbal and non-verbal parts of client stories, and should show respect for and belief in others. Some clients commented that some counsellors were distant and disengaged from observing their counsellors' non-verbal behaviour and from the mismatching comments made. Some shared the view that the counsellor's sexual orientation and their insistence on not talking about spirituality or religiosity were a concern for them. The dynamics were so diverse and powerful that some clients became uneasy even about the dress-code of the counsellor and the untidiness of the counselling setting.

This study reveal that some clients regarded the clinical aspects of the process as unhelpful due to the attitudes of some counsellors. Levitt and PiazzaBonin (2011) stressed the importance of the clients' perception of the therapists: whether the therapists were experienced as being distant, unempathic and giving unhelpful and impractical suggestions; they therefore regarded those sessions as 'unhelpful' (Lietaer, 1992; Granafaki & McLeod, 2002). Therefore, it is important for counsellors to know about their own transference feelings which can be positive or negative. One of the clients, for example, felt that his or her counsellor was not effectively distinguishing their sexual orientation and the client's, leaving her puzzled. Some counsellors admired their clients' motivation and perseverance for establishing a better life after living through horrifying events (Munday, 2009). Clearly working with ethnicity, culture, sexuality and spirituality at the same time may prove daunting if training does not address them well.

The counsellors also agreed that mental health practitioners should learn how to embrace unknowns, diversity and ambiguous situations. To them, maturity was about being calm, fair, wise, flexible and patient. Schweitzer, Wyk and Murray (2015) have noted the counsellor's ability to tolerate some degree of unknown aspects of cultural complexities is crucial.

Inadequate training is argued to be a major reason for therapeutic ineffectiveness in multicultural counselling (Sue et al., 1982). A survey revealed that clinicians' definition of ethnically sensitive therapy affects their practice in that they differentiated the cultural one from the pathologic one (Zayas, Torres, Malcolm and DesRosiers, 1996). Therefore, counsellors require well-thought out and more inclusive training programmes and clinical supervision in terms of finding 'a place to think', as Birkett (2006) stated, and discuss the emerging social, psychological and political issues.

Some counsellors vocalized their discomfort regarding who holds the power throughout the sessions. Some research literature show that overall responsibility for good interpreting belongs to on the clinicians (D'Ardenne et al., 2007; Costa, 2011; Miklavcic & LeBlanc, 2014). Practitioners are responsible for the well-being of the triad. If the interpreters are trained and supervised, an interpreter can take the responsibility of informing the practitioner about the client's underlying cultural expectations; and educate the client about the practitioner's working style, requirements and expectations, and about the interpreters' work boundaries. These should be delivered within the framework of a protocol which should regularly be updated by consulting practitioners, interpreters and service users. Interpreters will then be accountable to all involved. This would also provide an interim solution to an ongoing debate about the empowerment of interpreters.

The counsellors were required to have the skills and knowledge of self-care which included being able to manage the unexpected, and to talk about their work and stress in supervision. They must be aware of compassion fatigue or vicarious traumatization that can emerge because of the exposure to the stressful and traumatic contexts such as counselling victims of child sexual abuse, violent attacks or survivors of torture. Many researchers have highlighted the necessity for training related to personal development (Century, Leavey and Payne, 2007; Miller et al., 2005; Skovholt & Trotter-Mathison, 2011).

Interpreters shared their appreciation of the counsellors' efforts in laying trustworthy foundations with the clients. The counsellors achieved this by engaging with clients further

in order to learn about their backgrounds and their needs. This close monitoring involved clients being assigned to better or tailored services. Both interpreters and clients argued that the more experienced the counsellors, the more easily the needs were assessed, and suitable solutions found.

The findings reveal the counsellors' reluctance and lack of competence in working with religiosity and spirituality. To some clients, it was a significant part of their healing; but it did not seem to be acknowledged by the counsellors they saw. Some clients regarded the counselling as unhelpful when their experiences or their views were dismissed. There is a contentious debate about whether spirituality should be explored in counselling (Ross, 2016; Pargament, 2007). Training culture may sometimes, subtly, hinder working on these issues; one client commented that her counsellor did not work through those matters even though the counsellor was from her own culture. Therefore, failure to include these elements into the curriculum leads to make practitioners lacking confidence in addressing them in practice. Training in this area is seen to be lacking (Ross, 2016).

Clients' needs

The clients' needs and characteristics were detailed at length in the trust-related section. Therefore, the client needs will be summarised only briefly here to avoid repetition.

Anxiety in clients has a long history. An added communication difficulty such as language put them in a vulnerable position. They needed to be understood due to the multiple difficulties they presented in different aspects of their lives. They expected to be protected in terms of their well-being, their existence, and their struggle for survival.

Confidentiality was the most important matter for the clients throughout the study. It meant privacy, their private story, which had life and death connotation. They complained that privacy was not observed all the time, expecting that they would be dealt with by a limited number of staff or professionals. The interpreter's presence confused them, especially, when the staff became insensitive.

The clients felt that their stories of illness were sometimes looked down upon. Some clients felt that they could not convince service providers to pay enough attention when they were emotionally on the brink of a breakdown.

Another difficulty that the clients felt was about changing the staff with whom they were working. One likened this to feeling like a tennis ball. It is known that the health system in the UK promotes working in teams. However, this policy has been reflected in many patients/clients' lives as something that they could not keep up with and that they had to tell their stories to different professionals or agencies. This seems to violate their emotional stability. One client expressed the view that the sessions felt repetitive, feeling that they were not going anywhere. The feeling of being 'stuck' undermined clients' confidence. They agreed that their need was to be dealt with caringly and sensitively.

The analyses show that the clients were aware of the cultural luggage that they had brought with them. In that sense, they had some expectations from both the counsellors and the interpreters that they would be informed or educated about the culture and system of the host country.

Clients' responses also suggest that the clients utilised their intuitive skills to make assessments of the professionals helping them. Although limited in their verbal language, they used non-verbal clues to assess the motivation and competence of the counsellors and the interpreters.

They expected that the counsellors would not impose anything on their clients because the counsellors' religiosity, ethnicity or sexuality might interfere with their work. Some clients felt that some counsellors lacked empathy for the differences of their clients. One client described her experience as 'looking at emptiness'. They therefore felt that the counsellors needed considerable expertise to deal with certain topics. Knowledge of and interest in race and diversity, culture-related topics as well as of post-traumatic stress disorder in asylum seekers and refugees.

In summary, the clients' responses show that they needed to

- be listened to attentively
- be engaged intuitively
- be respected
- be working together
- be informed
- be assured that concerning complex issues such as spirituality and homosexuality would be managed.

In terms of the research question of to what extent non- English speaking clients felt helped, the clients expressed that they pretty much felt helped when they were understood, not judged, when they were listened to and when they were given advice.

Contributions to the research

This study has contributed to the research literature in a number of ways. It has added to the knowledge of counselling non-English speaking clients through interpreters. The overall main research question of how members of the triad made sense of the therapeutic and interpreting processes was answered by exploring all the members' understandings, approaches and expectations of the triad and the processes. The research will enhance the understanding of the dynamics further as the summative phrases and metaphors that the participants used have been added to the research literature (see Conclusion Section).

Further reflections made on the socio-political and economic aspects of the process have extended beyond the scope of the research: for example, the finding that the use of interpreters is determined by the economic factors but also invisibly by the racial tendencies of the policy-makers, is a significant outcome that calls for further study.

It has been highlighted how important training is for interpreters. Inter-professional Education is suggested as one way of facilitating more in-depth training. The research suggests that this move will enhance and inform the relevant fields with improved professional attitudes and skills in all practitioners including interpreters. The implications of the research are therefore extended to promote collaborative work and the incorporation of complex skills into training.

These findings both support the research literature and the philosophical position of the researcher that service provision and professional practice should aim for diversity, multiplicity and inclusivity. The pluralistic stance, proposed by Cooper & McLeod (2011), that mental health and linguistic practitioners should establish a therapeutic dialogue between themselves, encouraging more effort, more responsibility and a desire to change gives a guiding light. Cooper and McLeod (2007) have been critical that a single therapeutic perspective fails to address the full dynamics of human reality, suggesting evolving pluralistic approaches to psychotherapy. The results show that flexible and diverse working models and collaborative work through evolving dialogues with both clients and interpreters are likely to produce positive therapeutic outcomes.

This flexibility was mentioned by Avery (2001) who attempted to describe the extent of the radius that interpreters could possibly use when utilizing their interpreting skills and their modes of working. She argued that interpreting can be creatively extended from the conduit mode to the cultural broker, depending on the context and demands of the service providers (Figure 3).



Figure 3: Creative Tension in interpreting process.

The ‘Creative Tension’ model proposed by Avery can be extended as the models suggest that relationships are subject to contraction as well as growth for change in both fields. The same dichotomous working process, that evolves from one mode to the other, was applied to the therapeutic work in which the practitioner chooses multiple models of working throughout the process. In this study, the model is combined with the versatile and flexible nature of the counselling and therapeutic work. The researcher proposed that in the triadic process both fields operate on a flexible platform where new roles, rules and identities are created and negotiated. As McLeod (2013) mentioned Pluralistic Model of working for therapists, it can be argued that therapists and interpreters tailor themselves according to the needs of the clients, the practitioners and the organisations. Therefore, double creative tensions rather than one field-oriented tension take place in triadic relationships, and the researcher calls this ‘Creative Flexibility’ by which both counsellors and interpreters use different modes and models throughout (See Figure 4 and Figure 5).

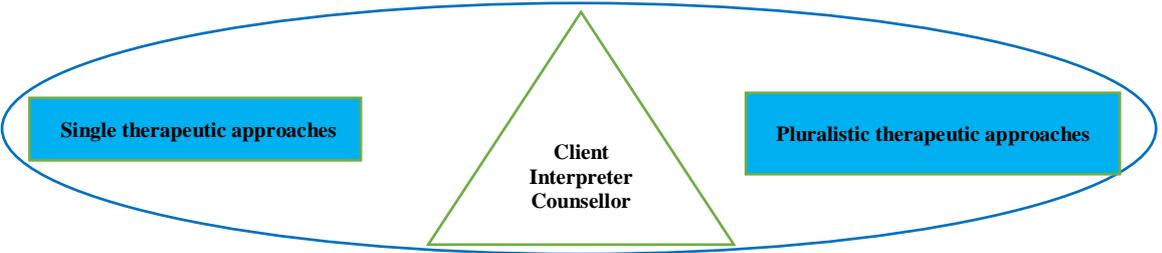


Figure 4: Creative Flexibility within the triadic therapeutic process.

Cooper and McLeod (2007) claim that pluralistic therapeutic approaches have an inherent creative tension in them so that they can be positively manipulated. Grant (2009) found that the interpreter moved from being a conduit to being a relational entity. The extended model, developed by the researcher, that are illustrated in Figure 4 similarly proposes that this tension functions as a growth or extension in which new actions, ideas and styles are invited into the relationship. The model also shows the factors that were claimed as being influential on the triadic therapeutic relationship and the interpreting process by all participant groups.

These complex relationships are managed by Creative Flexibility in which ongoing extensions represent a full range of interpreting models, therapeutic approaches and interventions with elements from the mainstream and other cultural healing systems. It also represents the practitioner's flexibility of using them when and where they are needed.

These two models are illustrated in Figure 5. This diagram also shows the common factors impacting on the triadic therapeutic and interpreting processes. It underlines the combination of ongoing functional tensions and extensions that were created by all involved. They are dealt with and worked through effectively by counsellors and interpreters, depending on their knowledge, skills and motivation.

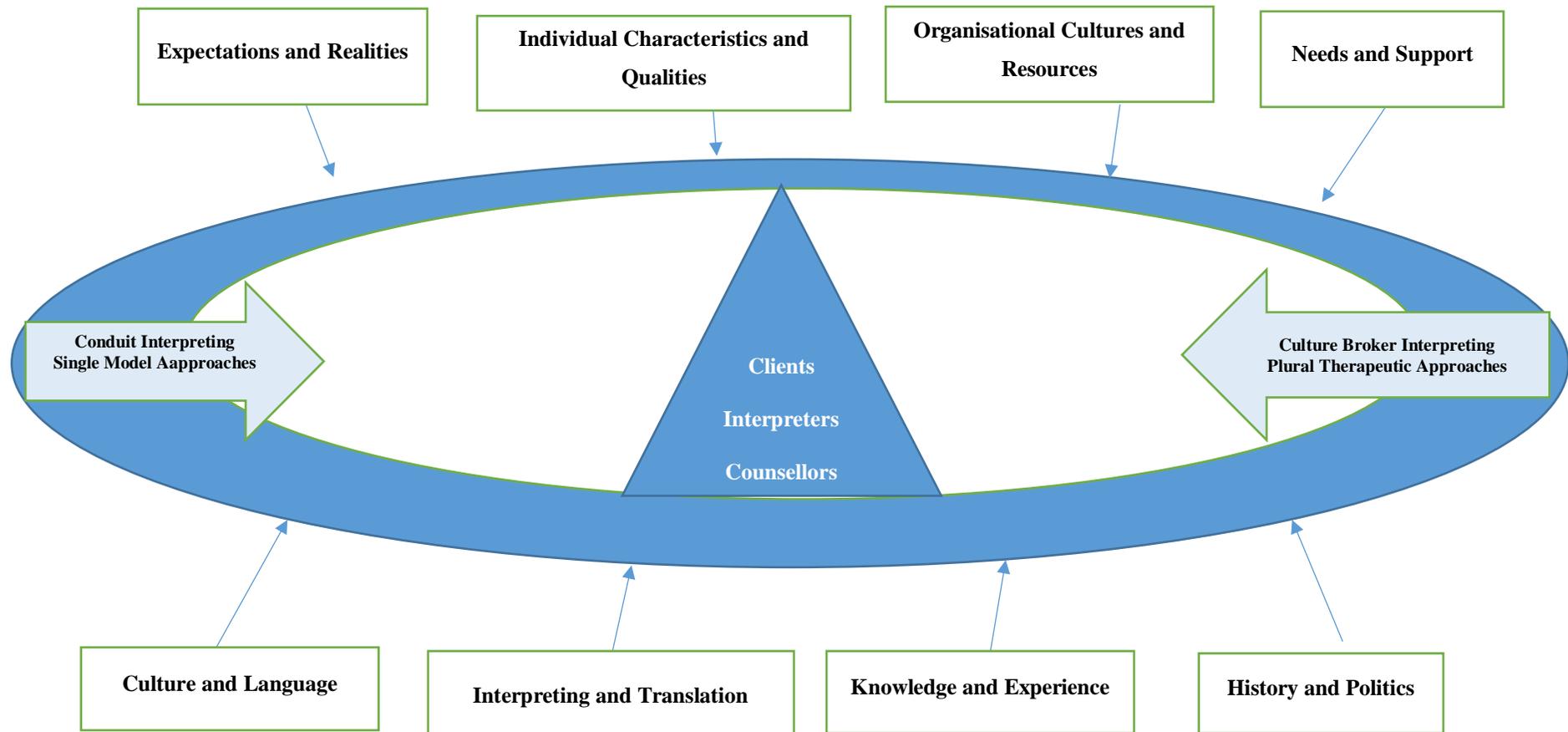


Figure 5: Creative Flexibility Model: The working models and approaches in Interpreting, and Counselling and Psychotherapy fields.

Contribution to knowledge

This section outlines the contribution of this study relating to the counselling, interpreting and mental health fields. It also brings different perspectives from other disciplines into this field. The analyses reveal that tailored trainings are paramount to the personal and professional development of both counsellors and interpreters. Isolated training for practitioners has proved to have a limited impact on their practice given that the socio-demographic nature of the society has been changing; hence the development of needs and requirements such as new conceptualisations for emerging practices (Costa & Briggs, 2014). Fields such as health, education, social care, counselling and therapy are working closer together as holistic and eclectic approaches have been developed in response to the complexity of the needs of clients/patients/customers. Thinking styles and thought processes of staff and the working culture of institutions need to be diversified and restructured to embrace the pressure to accommodate changes. The next section describes ways in which interpreters and counsellors are working on new approaches and practices through improved thinking processes and specialized training. Two concepts will be explored in relation to this aim: critical thinking skills and inter-professional education.

Critical thinking skills

Critical thinking is an essential part of accountability of any concerned profession. Skilled practitioners not only employ cognitive skills such as analysing cases, predicating, applying standards, and logical reasoning, but also to have characteristics such as intellectual integrity, intuition, perseverance, fair-mindedness, and deliberate and careful attention to thinking (Scheffer and Rubenfield, 2000; Paul, 1993).

Counsellors who can think critically are able to assess and evaluate the models and approaches they use as well as their own assumptions and expectations from the clients and interpreters and the organisational culture through which they practise. They are able to assess the impact of each member of the triad on the triadic relationship and to consider the socio-political, economic and socio-cultural aspects of the society in which they practise. Benner, Hughes and Sutphen (2008) add that critical reflection skills help practitioners to rethink outmoded approaches to healthcare and prevention of illness and complications, especially when new evidence is available.

Wheeler (2006; p.12) summarized this dynamic:

‘There is nothing easy about living and working with people who are different from ourselves and one of the most painful aspects is being confronted and shamed by our inevitable prejudices.’

Similarly, interpreters who can think critically are able to approach each session with an open-mindedness and flexibility so that they can effectively accommodate diversity and the needs of clients and counsellors. They can assess and manage sessions with clear understanding of the boundaries and the codes of conduct. They can clearly communicate their needs and difficulties with the relevant authorities and exercise intellectual curiosity to assess clients’ language proficiency, level of acculturation and concerns via gentle, wise and respectful questioning. Counsellors and interpreters should learn how to think critically in order to conceptualize the clients’ and counsellors’ thinking processes and act accordingly. Analytical thinking would help them to differentiate (LoFrisco, 2013) as well as appreciate the use of different models. Regarding the concerns of the participants that some practitioners did not demonstrate maturity when dealing with non-English speaking clients and working with interpreters. Critical thinking skills can address this difficulty as it entails developing intellectual traits such as intellectual humility, courage, empathy and intellectual integrity (Elder & Paul, 2008). Both interpreters and counsellors in this study agreed that they must possess passion that will enable them to genuinely engage with their clients. When passion combines with knowledge, experience and disciplined thinking, they will enjoy practising safely and achieve better therapeutic outcomes.

Then the question would be how is it feasible to foster these intellectual traits so that they can become habits. A possible training model suggested is explored below.

Inter-Professional Education

Inter-professional education (IPE) is a model that was pioneered and has been successfully practised in the UK. IPE is defined by the Centre for the Advancement of Interprofessional Education as ‘Occasions when two or more professions learn from and about each other to improve collaboration and the quality of care.’ (CAIPE, 1997, revised, p.8). It entails developing a common understanding amongst different professionals, and historically between Medicine and Social Work (Barr, 2002). Recently, speech therapy and the police force have joined this joint educative programme.

IPE has developed over the years to modify negative attitudes and perceptions, to remedy failures in trust and communication between professions (Carpenter, 1995a); to reinforce collaborative competence (Barr, 1998); to cope with problems that exceed the capacity of any one profession (Casto and Julia, 1994); to enhance job satisfaction and ease stress (Barr, 1998; McGrath, 1991); to integrate specialist and holistic care (Gyamarti 1986), and to create a more flexible workforce (Department of Health, 2000, 2001a) (cited in Barr, 1999a).

One of the models used in IPE is the Leicester Model that aims to deliver inter-professional learning outcomes and standards that were set by the UK, CAIPE (CAIPE, 1997). The Leicester Model promotes active learning with and from patients/clients/customers; reflective and experiential learning; collaboration and partnership, inquisitiveness, critical thinking and problem-solving skills. It has the potential to engage with a wide range of professional and non-qualified staff (Anderson & Lennox, 2009).

In the case of counsellors and mental health interpreters, they would develop a common understanding towards the functions and impact of interpreting, its impact on the triadic therapeutic work, the boundaries, self-care and cultural variations inherent in their work. As Barr (1998) explained, there would be common competencies and complementary competencies between different professions. Collaborative competencies are necessary to work effectively with others and include the ability to describe roles and responsibilities clearly to other professions; recognising and observing the constraints of roles, responsibilities and competency; working with other professions to review services, tolerating differences, misunderstandings, ambiguities and unilateral change in another profession; and entering interdependent relationships and teaching enterprise (Ibid, p.16). In this way, practitioners' overall understanding and confidence will be improved in relation to working with culturally different client groups, and interpreters' awareness of belonging to a professional representative body will be increased.

The model can accommodate joint training sessions for interpreters and mental health professionals, and perhaps other related healthcare workers. These sessions can cover the following topics:

- the definition of mental health, counselling and psychotherapy,
- common concepts and common mental health conditions,

- cultural representations of emotions and illnesses,
- the impact of languages,
- help seeking behaviours in different cultures,
- the nature of the triadic work,
- how to work with interpreters,
- contextual differences and models used,
- how different professionals practise, and
- what the codes of practices of each field are.

IPE has a merit in terms of finding a joint solution to the point that was made during one of the counsellors' interviews. One counsellor argued that they wanted to see interpreters accountable to the counsellors. It was a valid point, however, due to lack of regulations and support, the work of interpreters is not systematically monitored. As another counsellor participant explained, since interpreters are not trained to the extent that counsellors are, they cannot be as accountable in the way that counsellors are. The research supports this view that unlike therapists, interpreters are unlikely to be trained to understand the complexities of working with psychological trauma and the corresponding patient presentations and therefore may not have a theoretical framework to process the whole relationship (Brown & Stobart, 2008). Both views have some merits in their own right and IPE can be utilized in the pursuit of finding an effective solution.

Contributions to the methodology

This study has been informed and influenced by the researcher's genuine curiosity to understand more, her willingness to contribute to the already known, and her aspiration to be an academic and a reflective practitioner. It is well summarised by McLeod (2001) that we want to be an informed '*knower*' and to be part of the white-collar workforce within an expert field (p.5).

This study has come out of a need to make the dynamics of the triadic therapeutic relationship with non-English speaking clients available to academia and relevant sectors.

The research proposal is based on the real experiences of the researcher in different settings as a psychologist/counsellor, a researcher, and an interpreter/translator. The experiences of being a migrant, a patient of the National Health services and going through various socialisation and education processes have facilitated the understanding and appreciation of diversity, and awareness of professionals' frustrations and interpreters' difficulties. These experiences have also offered a safe platform for self-reflection. All these are the outcomes of the researcher's experiences with many hardworking, well-intended practitioners, and highly-skilled and hardworking altruistic interpreters and with clients from all over the world. This study was thus being inspired by curiosity and the willingness to give all the participants a voice through a carefully designed research project, grounding their contribution and appreciating their work.

An important contribution of this study would be the triangulation method that was used to ensure the quality of the research. In using triangulation, various aspects of the research phenomena were looked at from different angles and in this case, the triadic therapeutic relationship was explored by asking all three members of the triad to comment on their experiences. In this sense, the outcomes were cross-checked by the other members' perceptions, which gives the research the strength that the diverse experiences of all participants were explored in a single study. The emerging codes were monitored and compared in order to identify and analyse the similarities and differences across the data sets.

The voices of the participants were analysed in order to inform the sectors about the issues and concerns put forward. Participants, from the beginning, were offered the hope of alleviating their concerns by sharing them in confidence. Stiles (1993) and McLeod (2001) noted that empowerment in this uneven triadic relationship could be achieved or attempted by listening to everyone involved in the process. This was appreciated by all research participants, and was powerful for them. They stated off the record that they felt quite good about talking about the issues that they had been unable to discuss before with someone from the field in a confidential manner. They insisted that they had learnt a great deal from this process and as a result of the group interviews they had learnt from each other, normalizing or checking the credibility of their views. They further added that they had learnt from the researcher's feedback and actions on the points that they made which correlates with what Kvale's (1996) noted that one of the effects of a well-conducted

qualitative research is to give the informants new insights into the topic being explored (p.197).

Two types of transcripts, naturalised and denaturalised, were kept in this study (see Transcribing Process in the Methodology chapter). In addition to providing comprehensive notes and analyses, two versions of the transcriptions were used to capture the feelings and thought dynamics. This improves the truth value of the study, and establishes a more subtle and informed way of not missing any explicit and implicit points of the participants in a long research process.

Lastly, attempting to produce an ethically sound and meticulously employed research process by using the insights of the researcher and the sensitive handling of the participant encounters, it can be claimed that this research utilized mixed methods although it was not the primary aim. This has improved the quality of the research. It was not an idiographic inquiry. However, every transcript was treated as such and worked on individually instead of focusing on the individuals' background and characteristics in relation to the research questions.

In this research, the main aim was also not to produce a theory or a model. However, close readings and working on informed insights based on an extensive literature review have led the researcher to combine a model and an approach which could improve practice in both fields; an existing model in the interpreting field and the suggested approach within the counselling and psychotherapy field. The strength of the process can be seen in how thematic analysis can be taken one step further, blending the techniques.

Similarly, this study did not aim to be an interpretative phenomenological inquiry. Since the researcher did not have any experience of being a service user, this form of qualitative method was eschewed. However, the researcher has systematically utilized a sensitive approach and exercised empathy with the interpreter and counsellor participants from beginning to end. Therefore, this thematic analysis has been strengthened by adhering to the ongoing reflective practice similar to that of an IPA researcher. The researcher was not neutral and owned her position and experiences throughout.

Limitations of the study

No research is immune from weakness and limitations and this research is no exception. The current study involved interviewing clients whose English was not sufficient to

communicate in that language and for that reason a small purposive sample was used. Mostly Turkish speaking clients were approached to avoid double translations and further ethical concerns. This had an impact on the clients in both a positive and negative way; their responses might have been different with someone who did not share the same culture. The same point can be made about the fact that two Bosnian participants would differently respond to a researcher from their shared culture and language.

The recordings of the interviews were translated by the researcher. Although they were repeatedly checked, and some were further verified by an external bilingual academic, the researcher impact cannot be underestimated. A critical and fair-minded stance towards the text was observed throughout. There was an awareness that the aim was to convey their thoughts and feelings as faithfully as possible by engaging with the text in an analytical dialogue (Smith, Flowers and Larkin, 2009; p. 84), asking reflectively ‘What did the participant mean?’. Attention was paid to which words and phrases they preferred to use, focusing on the chosen words, metaphors and phrases used by the participants. However, this was not taken further to the field of linguistics. These were explored within the therapeutic field.

Since a small group of interpreters, counsellors and clients were interviewed, the sample size hinders generalisation. Diversity of the participants was ensured by recruiting across a wide geographical area including Birmingham, London and Leicester.

There is no doubt that different client groups would share different experiences. Although it was specifically the aim to recruit interpreters with mental health interpreting experience, this was not always achieved as some interpreters turned out not to have enough experience and knowledge in this field. Interpreters who specialized solely in mental health could produce different outcomes.

All the counsellors interviewed stated that they spoke more than one language, reflecting the range of diversity of the counsellor group in the West Midlands. The impact of the counsellors’ bilingualism or of their belonging to any ethnic minority was not explored further apart from being asked about these as socio-demographic characteristics. The findings might have been different if only dominant-culture counsellors were interviewed.

The researcher’s impact on the interpretative process of devising themes and categories cannot be ignored. The researcher takes responsibility for these intellectual processes by

scrutinizing her assumptions and expectations from beginning to end. In terms of checking the reliability and validity, the researcher tried to critically and intellectually utilize the supervision sessions and exchange the thoughts and practices with practitioners through personal communication. In terms of the reliability of the devised categories and the themes, a group of people comprising doctorate students and two counsellors, were asked to check the researcher's categorisation of the texts. Their inputs were further discussed and incorporated into the last version.

The researcher's impact on the participants and the process also cannot be ignored and this can be both positive and negative. If the participants had not known that the researcher was a psychologist and an interpreter; would their confidence be at different level from that she was shown? As a psychologist and researcher from an ethnic background working with diverse clients, it was not too difficult to show empathy and observe the boundaries during the interviews. The reactions of the participants to a novice researcher with limited experiences might have been different.

This research was strengthened by the triangulation method in which three participant groups were approached to provide a better and an inclusive picture of the phenomenon studied. However, mixed method research would further strengthen the study with quantitative and qualitative data exploring various aspects of the phenomenon. But that would require different research questions.

Despite the researcher's meticulous work, professional, reflective and critical stance, it would still be impossible to claim any neutrality. Although the researcher worked on the boundaries and ethics throughout, and did not see any of the interpreters, counsellors and clients whom she interviewed later, she was still within the fields of counselling and interpreting. It must also be noted that no full neutrality can be claimed towards the interpretation of the responses and the final outcomes due to the researcher's internal identification with the clients from her shared culture, the counsellors from her long-term profession and the interpreters from her second career.

Recommendations

In this section, first, the points made by the participants regarding policy development, research and training are outlined in the light of the analyses. Secondly, suggested skills and competencies for both counsellors and interpreters are listed.

Policies, Research and Training

- The curricula for Counselling and Psychotherapy should be more inclusive.
- More educators with wider and multiple perspectives should be trained and their training programmes should aim to attract more students from ethnic minority backgrounds.
- Culture and faith-sensitive talking therapies should be appropriately and widely, where necessary, implemented.
- Interpreters should be included in policy-making process and be a part of regulating organisations.
- Further research is needed to assess the impact of spirituality and sexuality of the members of the triad on the therapeutic and interpreting processes.
- There is a strong need for tailored supervision for counsellors working with ethnic minority communities. This support should be offered by supervisors who have developed their knowledge and acquired their experience in this field.
- More research is needed to inform the relevant fields of the standards that are expected from organisations which provide training and support to interpreters. These interpreting agencies are an active part of the whole process, and therefore have an impact on the recruitment and monitoring of the interpreters.

Competencies:

Counsellors should

- Educate themselves about the communities they will be working with.
- Assess clients' readiness to acquire knowledge of therapy and their conceptualisation of mental health and self.
- Inform the clients about what procedures will be followed, how they will be treated, how the services will be delivered and what their rights are.
- Consider providing clients with a written translation of important documents.

- Develop a flexible approach to accommodate interpreters' and clients' diverse nature and needs.
- Work with and within multicultural perspectives and adopt more pluralistic approaches.
- Aim to develop further personal qualities such as resilience, humility, fairness and wisdom.
- Be aware of varying linguistic and cultural variations that might occur due to working through interpretation and translation.
- Be attentive to verbal and non-verbal communicative gestures of the clients and interpreters.
- Critically understand subtle power imbalances inherent within the institutions and society, and be proactive in reducing some visible and invisible inequalities.
- Reflect on their own thought processes and prejudices, and evaluate the underpinnings of Western Counselling and Psychotherapy when working with culturally different clients.

Interpreters should

- Update themselves on linguistic skills and field-related knowledge through self-education, further training and supervision.
- Improve their knowledge of counselling, mental health and health systems of the UK.
- Be familiar with different client accents and identify the clients' proficiency in their mother tongue.
- Understand the clients' implied meanings, colloquial usages and emotions; and inform the counsellors about them.
- Have an insight into their own cultural assumptions, biases and beliefs about mental health and talking therapies.

- Recognize their own working style and adhere to the codes of conduct of the institution they work in.
- Be aware of potential sources of role conflicts, and work on boundaries.
- Be passionate, mature and non-judgemental, and improve inter-personal communication skills.
- Clarify their roles with clients and counsellors, and recognize that the main responsibility of the session belongs to the therapists.
- Understand and work on self-care.
- Look for opportunities to network and join in a representing body.

Implications and Dissemination

This study aimed to contribute to the literature and to make the information gained available to the relevant authorities and professionals concerned. Although good practice guidelines of the BPS and BACP for working safely and effectively with culturally diverse clients through the third person exist, the results suggest that these guidelines were not necessarily utilized well. It is hoped that the findings improve the use of these guidelines.

The results are expected to create further discussion and opportunities for both interpreters and counsellors to get the relevant support, namely training and supervision. Both groups presented a great need for this. The practice that the participants described seemed to be lacking appreciation and recognition. It is hoped that in addition to the efforts made by the practitioners, the personal investment of each member of the triad in the process including the clients' will be recognized by all. The triangulation method is hoped to provide a better picture of this dynamic enterprise.

The interpreters' training is expected to be taken further by the interpreting agencies and the institutions that employ interpreters. These organisations should take a lead in ensuring that their interpreters are supported to work safely and satisfactorily. Their training can be delivered to practitioners-to-be in different fields as a joint course when learning about mental health, illnesses, self-care and safeguarding and so on; for example, mental health classes can be taken attended by nurses, mental health professionals and interpreters together, using the Inter-Professional Education model.

Counsellors too will be expected to come forward and ensure the implementation of interpreting guidelines. They should get culturally aware supervision for themselves.

In terms of dissemination, these findings will ultimately be shared with the relevant professionals in both interpreting and mental health fields. Research articles will be written for the publication. The researcher will also seek to present and speak at national and international conferences. The findings that were initially obtained were presented in a series of academic events throughout. Similar activities in both fields will further be followed. Please refer to Appendix 26 for these work that were already presented and also for the activities that are planned for the future academic events.

It is hoped that this study will make some changes in terms of better outcomes and best practice in relevant fields for all.

Future research considerations

- Comparative research on clients' wider experiences of receiving emotional help through interpreters with client groups from other ethnic backgrounds.
- Exploration of interpreters' views about wider aspects of their work through a quantitative study across the UK.
- Further research on counselling and psychotherapy training in relation to working with third persons, language and culture.
- Exploration of what organisations and institutions that employ interpreters think about the issues regarding system related concerns.
- Impact of the gender of the interpreters on the counselling and interpreting processes.
- Further investigation of the meaning-making process in triadic therapeutic framework from a linguistic perspective.
- Creating debate on development of Interpreters Training using Inter-professional education model and integrating critical thinking skills into the curricula.
- Further research on the application of wider and inclusive counselling approaches and models to identify and accommodate the needs of refugee clients.
- Action research into service provision about providing supervision to interpreters and tailored supervision to counsellors.
- Large scale cross-sectional studies exploring the policy development in relevant fields.

Conclusions

This section provides a summary of the findings with further reflections. This study explored the underlying dynamics of the triadic therapeutic counselling relationship and sought to understand how each member of the triad made sense of the therapeutic and the interpreting processes.

Rich data were obtained from all participant groups. The interpreters' responses can be summarized, using their own metaphoric concepts; they were very concerned about the uncaring nature of their sector (*'Becoming emotionless robots!'*), the lack of recognition that they faced (*'Second class citizens'*), and emphasized the very nature of their job (*'We are humans.'*). They acknowledged that they needed more knowledge and further skills.

The counsellors' concerns were not very different from those of the interpreters in terms of their needs and support. They provided insights into the background of the difficulties, touching on wider socio-political, historical and economic aspects of the affairs at a larger scale. They described the process as emotional, broken and surprising. They used the following terms that summarize the complex nature of their work: *'blind process'*, *'lack of eureka moments'*, *'hot potatoes'*, *'having a smoke screen'* and *'a broken rhytm'*.

It can be claimed that no counsellor mentioned any model or approach superior to any of the available psychotherapeutic models. On the contrary, they emphasised the need for more inclusive and diverse therapeutic interventions through culturally sensitive and inclusive approaches. However, they described their daily work as being a *'Jack of all trades'* who does everything.

The client data can be summarised by the following rephrased overall feelings that were aired throughout. Their experiences in relation to the presence of the interpreters are captured in the statement *'I felt relieved!'* when first seeing the interpreter; but when sharing their intimate life experiences with a stranger was captured in the responses of *'I wish I wasn't here.'*; in terms of their perceptions of themselves before the authorities, one described their position as *'A tennis ball thrown to and fro'*.

In a world of differences, the most striking finding is that there were more similarities than differences across the participant groups when looked at from within. The universal needs and expectations were there. The clients, the counsellors and the interpreters valued and regarded the counselling and the interpreting processes as learning curves in their

development; they acknowledged and appreciated each other's needs and difficulties; and suffered from being unable to ensure trust and therefore desperately craved it. All participants demonstrated the virtue of intuition and wisdom in making sense of the process despite many obstacles.

Interpreters are inevitable necessities who add value or something vital; the clients are complex to work with but also a source of admiration; and counsellors may be perceived as powerful and knowledgeable or the agents of a discriminating and uncaring state. Nevertheless, they all acknowledged that they learnt from each other as well as hurt each other.

Perhaps this metaphor can depict their complex existence within the frame as this study has shown that not merely one member of the triad but also all of them thought that there was an ELEPHANT in the room but, more importantly, they felt that they themselves were that ELEPHANT!

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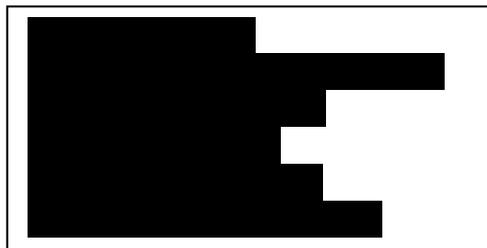
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APPENDICES

Appendix 1: Focus Group Information sheet sent to Interpreting

Agencies

(Name and address of the Interpreting Agency)



Dear Colleague (Name of the manager),

I am doing my doctoral study under the supervision of Prof Sue Wheeler in the University of Leicester. I am going to carry out a research project in the next 2 years. My research will be exploring how interpreters and mental health workers (counsellors, therapists, LIPT workers) make sense of interpreting process; and the impact of interpreting process on both interpreters and mental health professionals.

I am in the initial stage of my research. In this stage, rather than developing research questions on my own, I have decided to use focus groups method to find out what the interpreters, working in the field, think about related issues and to identify the important concerns for them.

In this regards, my supervisor (Prof Sue Wheeler at Lifelong Learning Institution in Leicester University) and I have thought to approach you first to recruit our participants, interpreters. We appreciate your time and effort to inform your interpreters to share this information, then to ask them to contact to the researcher, Merih Fidan, if they wish to take part in the group meeting. My details are at the top of this letter. I will need 1 or 2 interpreters from your agency (do not worry about gender and nationality).

The criteria on the interpreters we are looking for are: that they are 25 and over; that they have a minimum 3 years interpreting experience, and that they worked with mental health professionals in mental health settings.

The focus groups usually consist of 8-10 interpreters. I will be the facilitator and asking them some prompting questions like 'Tell me about a particularly good experience and a bad one.'; 'What are the interesting and uncomfortable aspects of your job?'; 'Have you had any interesting experience with an emotionally stressed client, a health care provider and a mental health professional?'; 'What do you think about training and support for interpreters' and so forth.

The participants who are willing to participate will be invited to the group talk on 11 May 2010 at 10.30 am in the address below. The group session will last about 1- 1.5 hours. Data protection will be ensured. The participants will have the right to withdraw from the research before or after focus group session.

The sessions will be recorded. Anonymity and confidentiality will be ensured throughout the research. Your interpreters do not have to use their real names. No names or information about the participants will be passed onto any other person or agency. They will also be given an access to the transcribed version of the group session if they wish.

Please note that participation will be voluntary. We appreciate your support. Travel expenses will be paid, and drinks and snacks will be provided on the day of meeting. If you wish to obtain further information, do not hesitate to contact to me on above details.

Thank you in advance for your support. I will look forward to hearing from your staff.

Kind Regards

Mrs. Merih Fidan

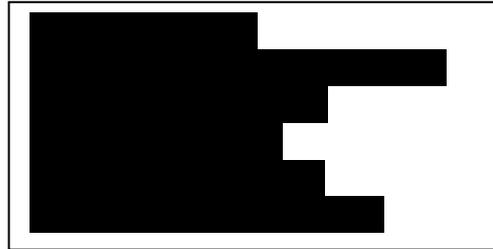
Address to meet:



Appendix 2: Focus Group Information sheet for Counselling

Organisations

(Name and address of the Counselling/
Psychotherapy Organisation)



Dear Colleague (name of the manager/director),

I am doing my doctoral study under the supervision of Prof Sue Wheeler in the University of Leicester. I am going to carry out a research project in the next 2 years. My research will be exploring how interpreters and mental health professionals (counsellors, therapists, LPT workers) make sense of interpreting process; and the impact of interpreting process on both interpreters and professionals.

I am in the initial stage of the research. In this stage, rather than developing research questions on my own, I have decided to use focus groups method to find out what the individuals working in the field think about the related issues, and to identify the important concerns for them.

In this regards, my supervisor (Prof Sue Wheeler at Lifelong Learning Institution in Leicester University) and I have thought to approach you first to recruit our participants, mental health professionals. What we want from you is to ask your counsellors/therapists to share this information first, then to inform them that they can contact to me if they wish to take part in the group meeting. My details are at the top of this letter. I will need 1or 2 (male or female) counsellors/ therapists from your organisation.

The criteria on the mental health worker/professionals we are looking for are that they are over 25; that they have related qualification in mental health field; that they have a minimum 3 years in mental health services; that they have worked with interpreters.

The focus groups usually consist of 8-10 counsellors. I will be the facilitator and asking them some prompting questions like 'Tell me about a particularly good experience and a bad one.'; 'What are the interesting and uncomfortable aspects of your job'; 'Have you had any interesting experience with an emotionally stressed client and an interpreter'; 'What do you think about training and support for interpreters and mental health workers' and so forth.

The participants who are willing to participate will be invited to the group talk on 14 May 2010 at 10.30 am in the address below. The group session will last about 1-1.5 hours. Data protection will be ensured. The participants will have the right to withdraw from the research before or after group session. The sessions will be recorded.

Anonymity and confidentially will be ensured throughout the research. The participants do not have to use their real names. No names or information about the participants will be passed to any other person or agency. They will also be given an access to the transcribed version of the group session if they wish.

Please note that participation is voluntary. We appreciate your support. Travel expenses will be paid, and drinks and snacks will be provided on the day of meeting.

If you wish to obtain further information, do not hesitate to contact to me on above details.

Thank you in advance for your support. I will look forward to hearing from your staff.

Kind Regards

Mrs. Merih Fidan

Address to meet: 

Appendix 3 : Focus Group Guide: Interpreters

Introduction of the Research

Opening question

1. Ask each participant to introduce themselves.

Introductory question

2. Has anything surprised or concerned you in working with therapists/counsellors for an ethnically different client?

Transition Question

3. Tell me about a particularly good experience and a bad one.

Key topic areas to cover

4. How did you feel after a session with an emotionally stressed client in a counselling setting?
5. Were you able to talk to anyone after a stressful session? If so, who?
6. How do you think that your presence affects the therapeutic work that a mental health professional offers?
7. What benefits / disadvantages have you experienced in working with therapists/counsellors?
8. Have you ever felt that everything that client said does not have to be translated or cannot be translated?
8. What do you think about service providers' and agencies' support for interpreters?
9. How would you like to be supported?
10. What do you think that the most important issue or concern in this profession nowadays?
11. What needs to be done in mental health field and interpreting setting?

Ending Questions

12. Is there anything else that you would like to add?.....

Thanking participants.

Appendix 4 : Focus Group Guide: Counsellors

Introduction to the Research

1. Ask each participant to introduce themselves.

Introductory question

2. Has anything surprised or concerned you in working with ethnically different clients through interpreters?

Transition Question

3. Tell me about a particularly good experience and a bad one in working through an interpreter in offering a therapeutic service.

Topic areas to cover

4. How did you feel after a session with an emotionally stressed client with an interpreter?
5. Were you able to talk to anyone after a stressful session? If so, who?
6. How do you think that the presence of an interpreter affect your therapeutic work?
7. What benefits / disadvantages have you experienced in working with interpreters?
8. Have you ever felt that everything you said was not translated or was difficult to translate?
9. How would you like to be supported in this type of practice?
10. What do you think that the most important issue or concern in this profession nowadays?
11. What needs to be done regarding working with interpreters in mental health field?

Ending Questions

12. Is there anything else that you would like to add?.....

Thanking participants.

Appendix 5 : Focus Group Consent Form: Interpreters

Informed Consent

‘Hearing the Unheard: Exploring the dynamics of interpreting in mental health field’.

The Researcher: My name is Merih Fidan, and I am a PhD student in the Institution of Lifelong Learning in Leicester University. I am conducting a qualitative research on interpreters and counsellors under the supervision of Prof Sue Wheeler.

The Research: The purpose of the study is to gain insight into how interpreters and therapists make sense of interpreting process. The study’s findings will contribute to the academia, the interpreting sector, and the mental health service provisions.

The Process: Your participation will involve joining a focus group meeting that aims to generate the most related issues and questions to be used in the bigger study in the future. The focus group meetings will last about 1 and 1/2 hour. The session will be tape recorded for later analysis.

Preparation: You do not have to prepare anything. Attendance and willing to share your experiences, feelings, and opinion will do a lot.

Risk: The study will not pose any risk to you. I will do my best to ensure that confidentiality is maintained and **YOU WILL NOT BE IDENTIFYABLE IN THE STUDY**. You can withdraw the study at any time, and may also request that any data collected from you not be used in the study.

*By signing below you agree that you have read and understood the above information, and would be interested in participating in this study.

- I agree to participate in this study that will be a part of the fulfilment of the requirements for the PhD degree at the Lifelong Learning Institution in Leicester University.
- I understand that my participation is voluntary.
- I understand that the data collected will be limited to this research.
- I understand that I will not be identified by name in the final product.
- I am aware that all records will be kept confidential in the secure place.
- I acknowledge that the contact information of the researcher, Merih Fidan.
- I understand that the data I will provide are not be passed onto any third part.
- I understand that I may withdraw from the study at any time.
- I understand that I will not be paid for the participation.

Participant’s Name: _____

Participant’s Signature: _____

Date: _____

Appendix 6 : Focus Group Consent Form: Counsellors

Informed Consent

‘Hearing the Unheard: Exploring the dynamics of interpreting in mental health field’.

The Researcher: My name is Merih Fidan, and I am a PhD student in the Institution of Lifelong Learning in Leicester University. I am conducting a qualitative research on interpreters and counsellors under the supervision of Prof Sue Wheeler.

The Research: The purpose of the study is to gain insight into how interpreters and therapists make sense of interpreting process. The study’s findings will contribute to the academia, the interpreting sector, and the mental health service provisions.

The Process: Your participation will involve joining a focus group meeting that aims to generate the most related issues and questions to be used in the bigger study in the future. The focus group meetings will last about 1 and 1/2 hour. The session will be tape recorded for later analysis.

Preparation: You do not have to prepare anything. Attendance and willing to share your experiences, feelings, and opinion will do a lot.

Risk: The study will not pose any risk to you. I will do my best to ensure that confidentiality is maintained and **YOU WILL NOT BE IDENTIFYABLE IN THE STUDY**. You can withdraw the study at any time, and may also request that any data collected from you not be used in the study.

*By signing below you agree that you have read and understood the above information, and would be interested in participating in this study.

- I agree to participate in this study that will be a part of the fulfilment of the requirements for the PhD degree at the Lifelong Learning Institution in Leicester University.
- I understand that my participation is voluntary.
- I understand that the data collected will be limited to this research.
- I understand that I will not be identified by name in the final product.
- I am aware that all records will be kept confidential in the secure place.
- I acknowledge that the contact information of the researcher, Merih Fidan.
- I understand that the data I will provide are not be passed onto any third part.
- I understand that I may withdraw from the study at any time.
- I understand that I will not be paid for the participation.

Participant’s Name: _____

Participant’s Signature: _____

Date: _____

Appendix 7 : Socio-demographic Questionnaire: Interpreters

Socio-demographic information questionnaire for interpreters

- 1) Name (optional):
- 2) Gender:
- 3) Age:
- 4) Marital status (Optional):
- 5) Education (latest course):
- 6) Main Occupation (if available):
- 7) Ethnic background:
- 8) How many languages can you speak?
- 9) Duration of living in the UK
- 10) How long have you been interpreting?
- 11) Have you received any formal or informal training?
- 12) Do you get any supervision towards your work?

Thank you.

Merih Fidan

Appendix 8 : Socio-demographic Questionnaire: Counsellors

Socio-demographic Information Questionnaire for counsellors

- 1) Name (optional):
- 2) Gender:
- 3) Age:
- 4) Education:
- 5) Occupation:
- 6) How long have you been doing this kind of job?
- 7) Ethnic background:
- 8) Are you bilingual / bicultural?:
- 9) Any formal or informal training towards working with ethnically different client?:
- 10) Do you get any supervision toward your work?:

Thank you.

Merih Fidan

Appendix 9 : Focus Group Ethical Approval Letter

To: MERIH FIDAN

Subject: Ethical Application Ref: mf151-f094

(Please quote this ref on all correspondence)

22/03/2010 14:16:45

Institute of LifeLong Learning

Project Title: HEARING THE UNHEARD: Exploring the Nature and the Dynamics of Interpreting process from Interpreters' and Therapists' Point of View

Thank you for submitting your application which has been considered.

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

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

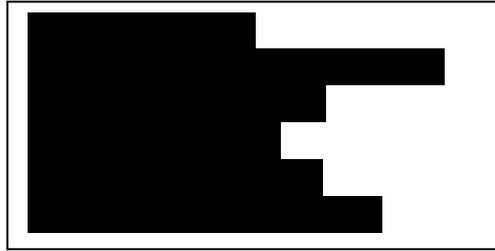
Approval is given on the understanding that the University Research Ethics Code of Practice and other research ethics guidelines and protocols will be compiled with <http://www2.le.ac.uk/institution/committees/research-ethics/code-of-practice>
<http://www.le.ac.uk/safety/>

--- END OF NOTES ---

Appendix 10 : In-depth Interview Information Sheet: Interpreters

Date:

Dear Colleague,



My name is Merih Fidan and I am doing my PhD in the University of Leicester. My research investigates the experiences of clients, counsellors and interpreters in a therapeutic relationship.

In the first part of the research, two focus groups with both interpreters and counsellors were carried out in order to find out the issues and main concerns. Many significant issues have emerged in these conversational sessions. I have developed some further questions from the analyses of the data and these questions will be asked in the second part of the research which is In-Depth interviews.

I am now approaching the second part of my research during which I will be exploring the topic further through individual interviews. I therefore kindly invite you for the individual interview to talk about your experiences as an interpreter working with counsellors or therapists. The criteria for taking part are being registered with an interpreting/translation agency; having a related training/qualification in the interpreting field; having minimum 2-3 years of working experience in mental health settings, preferable in counselling; and having worked with counsellors or therapists.

The interviews will be carried out in coming months. A neutral place based on mutual consensus will be found to carry out the interviews. You will be notified about it after you agree to take part. The interviews will last between 45-60 minutes. The session will be recorded. You will have the right to withdraw from the research before or after the interview. Data protection, anonymity and confidentiality will be ensured throughout the research. Your name or information about you will not be passed onto any other person or agency. You will also be given access to the transcribed version of the interview if you wish.

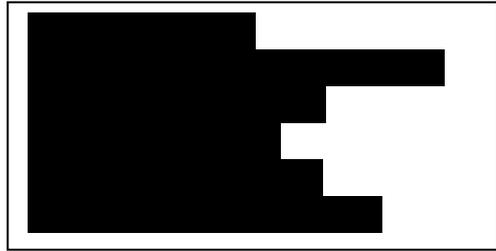
To thank you, your travelling expenses will be reimbursed (at the rate of a daysaver). If you wish to obtain further information, do not hesitate to contact to me on above details.

I would be very happy if you can let me know if you are interested in contributing to this exciting research. I will look forward to hearing from you.

With Regards

Merih B. Fidan

Appendix 11 : In-depth Interview Information Sheet: Counsellors



Date:

Dear Colleague,

My name is Merih Fidan and I am doing my PhD in the University of Leicester. My research investigates the experiences of clients, counsellors and interpreters in a therapeutic relationship.

In the first part of the research, two focus groups with both interpreters and counsellors were carried out in order to find out the issues and main concerns. Many significant issues and concerns have emerged in these conversational sessions. As a result, I have also developed further questions from the analyses of these data. These questions will be asked in the second part of the research which is In-Depth interviews.

I am now approaching the second part during which I will be exploring the topic further through individual interviews. I therefore kindly invite you for the individual interview to talk about your experiences as a counsellor or therapist working with interpreters. The criteria for taking part are having related training/qualification in counselling/mental health; having minimum 3 years of working experience in mental health; working with non-English speaking clients, and with language interpreters.

I will start carrying out interviews in coming months. A neutral place based on mutual consensus will be found to carry out the interviews. You will be notified about it after you agree to take part. The interview will last between 45-60 minutes. The session will be recorded. You will have the right to withdraw from the research before or after the interview. Data protection, anonymity and confidentiality will be ensured throughout the research. Your name or information about you will not be passed onto any other person or agency. You will also be given access to the transcribed version of the interview if you wish.

To thank you, your travelling expenses will be reimbursed (even if you don't travel), refreshments will be offered. If you wish to obtain further information, do not hesitate to contact to me on above details.

I would be very happy if you can let me know if you are interested in contributing to this exciting research. I will look forward to hearing from you.

With Regards

Merih B. Fidan

Appendix 12 : In-depth Interview Information Sheet: Clients [in Turkish]



Date: 23/4/2013

Sayın Bayan / Sayın Bay,

Merhaba. Ben Merih Fidan, Leicester Üniversitesi'nin Yaşamboyu Öğrenim Enstitüsü'nde doktora eğitimimi ve araştırmamı yapmaktayım. Prof Sue Wheeler' in danışmanlığında çalışmalarımı sürdürüyorum. Danışanlar (hastalar), danışmanlar ve tercümanlar arasındaki üçlü ilişki ve ilgili kişilerim deneyimleri üzerine kalitatif bir araştırma yürütmekteyim. Araştırmamın şu ana kadar ki aşamaları aşağıda sıralanmıştır:

Araştırmanın birinci kısmında, bir grup tercümanla ruhsal danışmanlar ve ingilizce bilmeyen hastalarla konusundaki fikirleri üzerine grup halinde görüşüm. Aynı şekilde bir grup ruhsal danışmanla yine grup halinde ingilizce bilmeyen hastalarla tercümanlar aracılığıyla çalışma konusundaki duygu ve düşünceleri üzerime görüşüm.

Araştırmanın ikinci kısmında, farklı tercüman ve danışmanlarla ayrı ayrı aynı konular üzerinde daha ayrıntılı bir şekilde daha ayrıntılı hikaye alabilmek amacıyla kayıt altında görüşüm.

Şimdi araştırmanın üçüncü kısmına geldim ve bu aşama ruhsal hizmetlerinden tercüman aracılığı ile faydalanmış bir grup danışan (hasta) ile görüşmeyi içeriyor. Çalışmanın koşulları şöyle:

Görüşmeler belli bir mekanda ya da üzerinde anlaşılan tarafsız bir yerde olacaktır, 45 ila 60 dakika arasında sürecektir. Görüşmemiz, sonradan analiz yapmama imkan versin diye kaydedilecektir.

Görüşmeler sakın ve rahat bir ortamda yapılacaktır. Yalnız ben sizinle olacağım.

Görüşmelerde söyleyecekleriniz gizlilik ilkesine göre saklanacaktır, dolayısıyla isminizi vermek zorunda değilsiniz. Bilgileriniz bir başka kişi ya da kuruluşla paylaşılmayacaktır.

Topladığım veriler elektronik ya da başka şekilde olsun her zaman güvenli ortamlarda ve şifreli bir şekilde saklanacaktır.

Dilerseniz çalışmadan çıkma hakkınız da vardır. Her soruya cevap vermemeye de bilirsiniz.

Çalışmaya katkıda bulunmanın size hiçbir riski olmayacaktır.

Görüşme esnasında duygusal açıdan olumsuz etkilenirseniz sizin için türkçe konuşan başsa bir danışman ayarlanacaktır. Bu kişi sizinle bir defaya mahsus ve görüşme esnasında neler olup bittiğine dair bir görüşme yapacaktır.

Eğer çalışmaya katılma kararı alırsanız bana telefonumdan (07989 480407) ya da e-mail adresimden (merih@fidan.co.uk) ulaşabilirsiniz. Ben de sizi geri arayıp ne zaman ve nerede görüşeceğimize karar vereceğiz. Görüşmemiz Axis Eğitim merkezinde olabileceği gibi benim daha önceden kullandığım bir başka organizasyonda da yapılabilir. Tesekkür amacıyla size küçük bir hediyem olacaktır.

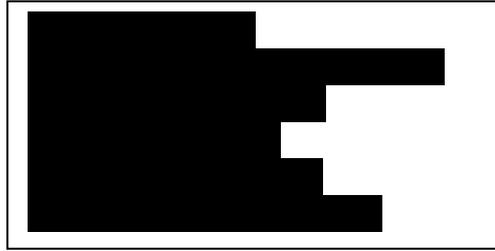
Çalışma hakkında daha fazla bilgi isterseiz benimle iletişime geçmekten çekinmeyin.

Sizden haber bekleyeceğim. Katkılarınız için şimdiden teşekkür ederim.

Saygılarımla

Merih Bektaş Fidan

Appendix 13 : In-depth Interview Information Sheet: Clients [in English]



Date: 20/9/2013

Dear Participant,

My name is Merih Fidan and I am doing my PhD in understanding of the triadic relationship between the client, interpreter and counsellor under the supervision of Professor Sue Wheeler at the University of Leicester. My research investigates the experiences of clients, counsellors and interpreters when working in a triadic framework of therapy.

My research is divided into three stages as follows:

- In the initial stages of my research, I engaged a group of interpreters and counsellors in two group sessions to discuss their experiences in working with counsellors and non-English speaking clients.
- At the second stage, I individually interviewed counsellors and interpreters to explore their experiences of working with non-English speaking clients through interpreters. I conducted semi-structured face- to- face one- to- one interview in order to further explore and establish the issues and concerns mentioned in the focus groups held in the first stage.
- I am now approaching the third stage of my research and at this phase, I would like to hear from clients who have received or are currently receiving emotional support from a counsellor or another mental health professional with the help of an interpreter.

You, the participant, will be asked to take into account the following considerations:

- I will ask you to talk about how you felt when you talked to a counsellor about your emotional difficulties through an interpreter and to what extent you felt understood;
- Whether or not you were able to say everything that you wanted/needed to, and if you experienced anything that was helpful or unhelpful during the counselling.
- What you felt about the presence of the interpreter and in what ways you think the interpreter influenced the process.

The Interview outline will be as follows:

- The interview will last for about 45 – 60 minutes.
- I will ensure that the environment is calm, therapeutic and relaxing.
- Only you and I will be present in the room.
- I will allow you plenty of flexibility and time to think about your responses to the interview questions.
- You have the right to refuse to answer any questions that you don't feel comfortable with.
- The Interview will be recorded and transcribed for future analyses.
- Any data collated will be securely kept by both paper and electronic means, this will be encrypted by password and kept in a locked cabinet.
- I am NOT going to use your real name in any writing or reporting. You can choose a name that you want to be called by throughout the process.
- Whatever you choose to share with me will be maintained with utmost confidentiality and shall not be passed on to another person or organisation.
- You have the right to withdraw from the research before or after the interview.
- **There will be no risk to you whatsoever. However, if the interview cause you any distress, you will have the opportunity to talk to a counsellor for one session only regarding the interview process only.**

If you would like to take part in this study you may contact me on mobile 07989 480407 or email me at [REDACTED]. Once you will be given an appointment time, I will explain how it will work and what we will be doing. After the interview has finished, I will similarly debrief you about how the interview went and what I will be doing next regarding what you have told me.

In the meantime, should you wish to obtain further information, do not hesitate to contact me. I have enclosed a consent form for you to sign should you decide to accept participation in this study.

I look forward to hearing from you soon.

With Regards

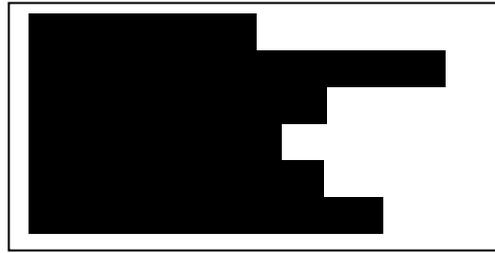
Merih B. Fidan

Appendix 14 : Letter sent to the community organisation for client recruitment

Eurasia Educational Society

270-272 High Street

Smethwick



Dear [REDACTED] and Mrs. [REDACTED],

23/01/2012

I am writing to you to ask if you help me conducting my in-depth interviews with clients. As you know, my name is Merih Fidan and I am doing my PhD under Prof Sue Wheeler's supervision in the University of Leicester. My research investigates experiences of clients, counsellors and interpreters in a therapeutic relationship.

I would like to give some background information about the research I have been working on for the last three years. In the first part of the research, I did talk to a group of interpreters about how they felt and thought about working with counsellors in mental health settings in helping non-English speaking clients. I then talked to counsellors in a group setting to get their feelings and views about working with non-English speaking clients through interpreters.

In the second stage of the research, I talked to a group of both interpreters and counsellors individually in a lengthy interview in order to get their views and feelings about the topics given above. They provided their views separately to me in detail about what can be done to achieve effective sessions and offer better services; both interpreters' and counsellors' needs in terms of training and supervision.

Now, I am in the third stage of my research. In this part, I wanted to hear from clients who had received counselling or therapy from any mental health professionals through interpreters. We wanted to do it in order to get a better and balanced idea about what happens in a counselling process and interpreting process in a triadic situation. Potential clients will be asked about how they felt when they had to talk about their emotional

problems to a counsellor when the third person, the interpreter was present; about what happened as they progressed; what did they think about the counsellor's and the interpreter's approach to the whole situation as well as the services.

Let me tell you little bit about the ethical aspects of the process, which Leicester University Ethics Committee will have to confirm it before starting. The interview will last about 45 – 60 minutes. Only the client and I will be in the room. The conversation will be recorded so that I can do analysis later on. I am NOT going to use their real name in the research and reporting. Whatever they will tell me will be confidential and not be passed to other people. If they want to see any reports to be produced, they can. They will have the right to withdraw from the research before or after the interview.

I believe that your well-known involvement with the community members might give me the opportunity of finding hard-to-reach people who had gone through a mental health difficulty. The criteria for clients would be that they experienced psychological difficulties and were offered help by counsellors or therapists through interpreters. So, if you had known anyone who fit in these criteria from any gender and background as long as they can speak Turkish language, I would be happy if you inform them about the study. If they wish to take part, you can give them my details to contact to me. Or you can me their details to me so that I can contact to them.

Also, I would like to ask you if I could use the centre where you offer various services. I believe that some members might wish to be seen at the centre. If that's Ok for you, I can invite them. If not, that's OK, I will be able to see them in a neutral place to both sides.

To thank them, their travelling expenses will be reimbursed (even if you don't travel), refreshments will be offered at the premise. If you wish to obtain further information, do not hesitate to contact to me on above details.

I will look forward to hearing from you.

With Regards

Merih B. Fidan

Appendix 15 : In-depth Interview Questions: Clients [in Turkish]

İngilizcesi yeterli olmayan danışanların (hastaların) tercümanlar aracılığıyla ruhsal destek alma deneyimleri

İsim (tercihli) ya da kod:

A. Socio-demografik bilgi: Danışan/ Hasta

DANIŞAN Cinsiyet: Yaş: Meslek: Eğitim: Uyruğu: Konuştuğu diller?	TERCÜMAN Cinsiyet: Yaş: Meslek: Uyruğu:	DANIŞMAN Cinsiyet: Yaş: Meslek:
--	---	--

B. Aşağıdaki ifadeleri, verilen skalayı kullanarak cevaplayınız.

1. Danışmanlık hizmetleri size ne kadar faydalı oldu?

Oldukça faydalı

Biraz faydalı Ne Faydalı Ne Faydasız

Pek faydalı değil

Hiç faydalı değil

2. Niçin bu şekilde düşünöyorsunuz?

3. Sizce, ruhsal danışman sizi ne kadar anlayabildi?

Herzaman Genellikle Bazen Nadiren Hiçbir zaman

4. Bunu biraz açabilir misiniz?

5. Sizce tercüman orda olmasaydı, danışman farklı davranır mıydı?

Evet

Hayır

6. Niçin? Ne deęişirdi?

7. Oturumlar esnasında söylediklerinizin gizli tutulma hakkına saygı gösterildi mi?

Evet

Hayır

8. Bunun için ne yaptılar?

C. Şimdi, sizinle birlikte danışmanın ve tercümanın bir arada olduęu bir oturumu düşünerek soruları cevaplayın.

9. Tercümanı odada ilk gördüğünüzde neler hissettiniz?

.....

10. Oturumlardan önce tercüman ile tanışıyor muydunuz?

Evet

Hayır

11. Evetse, ne vesile ile tanışıyordunuz, örneğin sizin toplumdan olduğu ve öğretmen olduğu için vs?

.....

12. Sizce oturumlarda kontrol kimin elinde idi; tercümanın ya da danışmanın, ve bu size neler düşündürdü?

.....

13. Tercüman sizi yargıarcasına davranıyor muydu? Nasıl ve hangi konuda böyle davrandı?

.....

14. Peki, danışman size yargılayıcı davranıyor muydu? Nasıl hareket etti ve bunlar hangi konuda oldu?

.....

15. Kendinizi tercüman aracılığı ile rahatça ifade edebildiniz mi?

Evet

Hayır

16. Tercüman orada olduğu için danışmana söyleyeMEDiğiniz şeyler oldu mu?

a. Evet oldu. Ne idi bunlar? (söyleyebilecekseniz)

b. Hayır. Her şeyi söyleyebildim.....

17. Tercümanla oturumlar dışında herhangi bir konuda konuşmayı ister miydiniz? Niçin?.....

18. Danışmanın sizi anladığını nasıl anlayabiliyordunuz?.....

19. Tercümanın sizi anladığını neye bakarak anlayabildiniz?.....

20. Danışmanın sizi anlaMAdığını ya da yanlış anladığını nereden anlıyordunuz?

21. Tercümanın sizi anlaMAdığını ya da yanlış anladığını nereden anlıyordunuz?.....

22. Tercüman size karşı sempatik miydi?.....

23. Danışman size karşı sempatik miydi?.....

24. Tercüman, profesyonel davranıyor muydu? Evet Hayır

25. Danışmanın size karşı profesyonel davrandığını hissettiniz mi? Evet Hayır

26. Danışmanın cinsiyeti sizi rahatsız etti mi? Evet Hayır
27. Tercümanın cinsiyeti sizi rahatsız etti mi? Evet Hayır

28. Tercümanla aranızdaki ilişkiyi hangi faktörler etkilemişti. Uygun olanları işaretleyiniz.

- Onun etnik kökeni Siyasi ve dini duruşu
- Konuşma şekli Dıştan görünüşü
- Kndine güveni Güvenilir olup olmaması
- Hastaya karşı olan tavırları Sürekli onun gelmesi
- Dil konusundaki becerileri Profesyonel çalışması, örn. Gizlilik ilkesine sadık kalması
- Diğer faktörler:

29. Danışmanla ve tercümanla olan iletişiminizin kalitesi hakkındaki duygu ve düşüncelerinizi aşağıda verilen 1-5 arası skalayı kullanarak belirtiniz lütfen. Skala üzerinde 5 'Her zaman', 1 'Hiç bir zaman' anlamına gelmektedir.

	Danışman					Tercüman				
Açık ve samimi	1	2	3	4	5	1	2	3	4	5
Rahat	1	2	3	4	5	1	2	3	4	5

Güvenilir	1	2	3	4	5	1	2	3	4	5
Kapalı	1	2	3	4	5	1	2	3	4	5
Gergin / Huzursuz	1	2	3	4	5	1	2	3	4	5
Şüpheli	1	2	3	4	5	1	2	3	4	5

30. Oturumlar boyunca danışmanla olan ilişkinizi engelleyecek/olumsuz etkileyebilecek herhangi bir şey oldu mu?

Evet Hayır

31. Ne idi bu durum ve nasıl oldu?.....

32. Oturumlar boyunca tercümanla olan ilişkinizi engelleyecek/olumsuz etkileyebilecek herhangi bir şey oldu mu?

Evet Hayır

33. Ne idi bu durum ve nasıl oldu?.....

34. Eklemek istediğiniz başka bir şey var mı?.....

Teşekkür ederim

Merih Fidan

Appendix 16 : In-depth Interview Questions: Clients [in English]

Non-English speaking clients' experiences of receiving counselling through interpreters.

Name (optional) or code:

A. Socio-demographic information:

CLIENT Gender: Age: Occupation: Education: Ethnicity: Which languages do you speak?	COUNSELLOR Gender: Age: Occupation: Ethnicity:	INTERPRETER Gender: Age: Occupation: Ethnicity:
---	--	---

B. Please answer the following statements, using the scales provided.

1. To what extent did you find counselling helpful?

Very helpful	Helpful	Neither helpful nor unhelpful	Unhelpful	Very unhelpful
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. Can you explain why you felt in that way?

.....

3. To what extent did you feel understood by the counsellor?

Always Usually Sometimes Rarely Never

4. Can you elaborate it for me? Why did you feel like that?

.....

5. Do you think that the counsellor would have performed differently if the interpreter was not there? Yes No

6. Why? What would change?

7. Did you feel that your confidentiality was respected during counselling sessions? Yes No

8. How do you think it was ensured?

C. Now, think about a specific session that you were with a counsellor and an interpreter, and answer the questions.

9. What feelings did you have when you first saw the interpreter in the room? ...

.....

10. Had you met the interpreter before the sessions? Yes No

11. If so, what was the relationship with him or her, e.g. community member, teacher?

.....

12. Who did you feel had control during the sessions, the interpreter or the counsellor, and what made you think that?

.....

13. Did you observe the interpreter being judgemental to you? How and what was it?

.....

14. Did you observe the counsellor as being judgemental to you? How and what was it?

.....

15. Were you easily able to express yourself through the interpreter? Yes No

16. Was there anything that you could not say to your counsellor because of the interpreter?

a. Yes. What was it? (if you can)

.....

b. No. Why could not you say it?

.....

17. Would you have liked to talk to the interpreter about any other issues outside the session?

.....

18. What evidence was there that the counsellor understood you?

.....

19. What evidence was there that the interpreter understood you?

.....

20. What evidence was there that the counsellor did NOT understand or misunderstand you?

.....

21. What evidence was there that the interpreter did NOT understand or misunderstand you?

.....

22. How sympathetic did you feel that the interpreter was towards you?

.....

23. How sympathetic did you feel that the counsellor was towards you?

.....?

24. Did you feel that the interpreter behaved in a professional way towards you?

Yes No

25. Did you feel that the counsellor behaved in a professional way towards you?

Yes No

26. Did the gender of the interpreter or the counsellor bother you? Yes No

27. Did the gender of the interpreter or the counsellor bother you? Yes No

28. What factors had an influence on the relationship between you and the interpreter? Tick all apply.

- | | |
|---|--|
| <input type="checkbox"/> Her/His ethnic background | <input type="checkbox"/> His/ Her Political and religious background |
| <input type="checkbox"/> How they speak | <input type="checkbox"/> How they look |
| <input type="checkbox"/> His/ Her Confidence | <input type="checkbox"/> Being trustworthy |
| <input type="checkbox"/> Their attitude to the client | <input type="checkbox"/> Consistency in seeing them there |
| <input type="checkbox"/> Linguistic skills | <input type="checkbox"/> Professionalism, e.g confidentiality |
| <input type="checkbox"/> Other: | |

29. Please rate your feelings about the **quality of the communication** with your counsellor and the interpreter at that time, using 1-5 scale where 5 means Always 1 means Never.

	<u>Counsellor</u>					<u>Interpreter</u>				
Open and friendly	1	2	3	4	5	1	2	3	4	5
Relaxed	1	2	3	4	5	1	2	3	4	5
Trustable	1	2	3	4	5	1	2	3	4	5

Closed	1	2	3	4	5	1	2	3	4	5
Tense / uncomfortable	1	2	3	4	5	1	2	3	4	5
Distrust	1	2	3	4	5	1	2	3	4	5

30. Did anything happen during the sessions which might have been hindering your relationship with the counsellor?

Yes No

31. What was it and how did it happen?

32. Did anything happen during the sessions which might have been hindering your relationship with the interpreter?

Yes No

33. What was it and how did it happen?

.....

34. Would you like to add anything further?

.....

Thank you. Merih Fidan

Appendix 17 : In-depth Interview Guide: Interpreters

Questions

- 1) **Introductory question:** What do you think about interpreting in mental health setting and working with mental health professionals?
- 2) **Transition Question:** What kind of help do you think you offer to clients and counsellors?
- 3) What do you think about interpreting only what it was said? Has it been problematic for you?
- 4) How does it affect your work when you want to understand the client further by asking more questions or talking to the client before the sessions?
- 5) How do your clients' nature and state affect your work?
- 6) Have you ever been caught up by the translation related problems and how did you cope with that?
- 7) What kind of support did you need during your work and from whom?
- 8) How organisational and managerial matters influence your work?
- 9) How do you think interpreting as an occupation is related to local and national/ international politics?
- 10) **Ending Questions:** Would you like to add anything?

Thank you.

Merih Fidan

Appendix 18 : In-depth Interview Guide: Counsellors

1. **Introductory question:** Tell me little bit about you.
2. What is it like working with non- English speaking clients?
 - a. *I would like to ask you to focus on the last session you had with a client and an interpreter?*
3. Does this session reflect your general experiences with interpreters?
 - a. How did the interpreter help or hinder you in establishing a relationship with the client?
 - b. To what extent did you feel that the session worked and the client was helped?
 - c. How confident were you that the interpreter translated everything that was said and translated it accurately?

(Now, please think about a session with a client and an interpreter that you would like to talk about)

4. How do you think clients' beliefs, cultural understanding and practices; and also their physical health, history of mental health and level of stress influence your work?
5. Was there anything you would have wanted to say the client but you did not because of the presence of the interpreter?
 - a. What would have helped you to use the interpreter more effectively?
 - b. How could sessions with interpreters be improved to be more satisfactory?
6. Is there anything that could help you manage sessions more successfully?
7. How do organisational and managerial issues influence your work?
8. **Ending Question:** Is there anything that you would you like to add?

Thank you.

Merih Fidan

Appendix 19 : In-depth Interview Consent Form: Clients [in Turkish]

ARAŞTIRMA IZIN FORMU

Danışanlar, danışmanlar ve tercümanlar arasındaki üçlü terapötik ilişki deneyimlerinin incelenmesi

Araştırmacı: Benim adım Merih Fidan, Leicester Üniversitesi'nin Lifelong Learning Enstitüsü'nde doktora yapmaktayım. Prof Sue Wheeler' in danışmanlığında danışanların, danışmanların ve tercümanların deneyimlerine yönelik kalitatif bir araştırma yürütmekteyim.

Araştırma: Bu çalışmanın amacı danışan, danışman ve tercüman arasındaki üçlü ilişkiyi incelemektir. Araştırma bulguları İngiltere'de İngilizce konuşmayan hastalar için tercümanlık ve ruh sağlığı alanında hizmetlerin geliştirilmesine katkıda bulunmayı amaçlamaktadır.

Süreç: Araştırmaya katılımınız, araştırmacı ile yapılacak mülakata iştirak etmeniz şeklinde olacaktır. Görüşme, 45 ila 60 dakika sürecek ve kaydedilecektir. Görüşme kayıtedilecek ve sonradan analiz edilebilmesi için transkripti çıkartılacaktır. Fakat hiçbir şekilde isminiz kullanılmayacaktır. Söyledikleriniz araştırma harici hiçbir yerde kullanılmayacaktır. Görüşmeler bir Türk eğitim merkezinde yapılacaktır. Görüşme öncesi izniniz alınacaktır.

Hazırlık: Herhangi bir şey hazırlık gerekmiyor. Duygu ve düşüncelerini paylaşmanız yeterlidir.

Risk: Araştırmaya katılmanın size hiç hiçbir riski olmayacaktır. Profesyonel bir yaklaşımla verşler saklanacaktır. Söyledikleriniz aramızda kalacaktır. Çalışma boyunca kimse sizin katıldığınızı bilmeyecek ve isminiz kullanılmayacaktır. Araştırmadan istediğiniz zaman çıkabilirsiniz. Ayrıca söylediklerinizin araştırmada kullanılmamasını da isteyebilirsiniz.

*Aşağıya imzanızı atayarak, belgeyi okuduğunuzu, bilgileri anladığınızı ve çalışmaya katılmaya istekli olduğunuzu kabul ediyorsunuz demektir.

- Leicester Üniversitesi'nin Lifelong Learning Enstitüsü'deki doktora programının bir parçası olarak bu çalışmaya katılmayı kabul ediyorum.
- Katılımın isteğe bağlı olduğunu anlıyorum.
- Araştırma için toplanacak verilerin yalnızca bu çalışmayla sınırlı olacağını anlıyorum.
- En sonunda ortaya çıkacak olan eserde adımın yazılmayacağını anlıyorum.
- Kaydedilen herşeyin güvenli bir yerde gizlilik ilkesi gereğince saklanacağını anlıyorum.
- İletişim kurulması gereken kişinin Merih Fidan olduğunu biliyorum.
- Söyleyeceğim şeylerin başka üçüncü bir tarafa aktarılmayacağını anlıyorum.
- İstediğim anda çalışmadan çekilebileceğimi biliyorum.
- Ruh sağlığım açısından endişe verici durumlar ortaya çıktığı takdirde araştırmacı, Merih Fidan'a, bu durumu aile doktoruma bildirme iznini veriyorum.

Katılımcının Adı (Tercihli): _____

Katılımcının İmzası: _____

Tarih: _____

Appendix 20 : In-depth Interview Consent Form Clients [in English]

Research Title: An investigation of the experiences of the therapeutic relationships between the client, counsellor and interpreter within the triadic framework of therapy.

The Researcher: My name is Merih Fidan, and I am doing my doctoral degree under the supervision of Prof Sue Wheeler in the Institution of Lifelong Learning in Leicester University. As part of the study, I am conducting a qualitative research on the dynamics of triadic therapeutic relationships between clients, counsellors and interpreters.

The Research: The purpose of the study is to gain an insight into the therapeutic relationship between the three; the client, the counsellor and the interpreter. The findings will be used to contribute interpreting sector and the mental health service provisions for non-English speaking clients in the UK.

The Process: Your participation will involve taking part in a semi- structured interview with the researcher. The in-depth interview will last between 45 and 60 minutes. It will be recorded and transcribed verbatim. The data will securely be kept by both electronic means and using a locked cabinet. The data will not be shared with a third party. Your input will not be used for anything other than the stated research purposes, if it will be, your permission will be taken beforehand. The interview will take place in a Turkish organisation in Birmingham and its details will be given when agreed to meet.

The Risk: The study will not pose any risk to you. Confidentiality and anonymity will be ensured. The interview will be managed, using the professional codes of conduct. Your real name will not necessarily be taken, **YOU WILL NOT BE IDENTIFYABLE DURING AND AFTER THE STUDY**. You will still be asked to create a pseudo name to identify you throughout the study. You can withdraw from the study at any time, and may also request that the data collected from you not be used in any writing or reporting. You will be able to see a Turkish speaking counsellor for one session only if you feel that the interview causes you any distress.

Preparation: You do not have to prepare anything. All information will be sent to you.

*By signing below you agree that you have read and understood the above information, and would be interested in participating in the interview.

- I agree to take part in this study that will be a part of the fulfilment of the requirements for the PhD degree at the Lifelong Learning Institution in Leicester University.
- I understand that my participation is voluntary.
- I understand that the data collected will be limited to this research.
- I understand that I will not be identified by my real name.
- I am aware that all records will be kept confidential in a secure place.
- I acknowledge that the contact information of the researcher, Merih Fidan, has been given to me.
- I understand that the data I will provide will not be passed onto any third part.
- I understand that I may withdraw from the study at any time.
- I understand that should my state of my mental health raise any concerns for my wellbeing and the wellbeing of others then I give consent to the researcher, Merih Fidan, to contact my GP.

Name: (Optional) _____ Participant's Signature: _____ Date: _____

Appendix 21 : In-depth Interview Consent Form: Interpreters

Informed Consent

Investigation of the experiences of clients, counsellors and interpreters in a triadic therapeutic relationship.

The Researcher: My name is Merih Fidan, and I am a PhD student in the Institution of Lifelong Learning in Leicester University. I am conducting a qualitative research on interpreters, therapists and clients under the supervision of Prof Sue Wheeler.

The Research: The purpose of the study is to gain insight into the triadic relationship between the client, the interpreter and the counsellor. The study's findings will contribute to the academia, the interpreting sector, and the mental health service provisions.

The Process: Your participation will involve joining an in-depth interview with the researcher. The in-depth interviews last between 45 and 60 minutes. The session will be tape recorded.

Preparation: You do not have to prepare anything. Willingness to share will be enough.

Risk: The study will not pose any risk to you. I will do my best to ensure confidentiality. **YOU WILL NOT BE IDENTIFYABLE IN THE STUDY.** You can withdraw from the study at any time, and may also request that any data collected from you not be used in the study.

*By signing below you agree that you have read and understood the above information, and would be interested in participating in this study.

- I agree to participate in this study that will be a part of the fulfilment of the requirements for the PhD degree at the Lifelong Learning Institution in Leicester University.
- I understand that my participation is voluntary.
- I understand that the data collected will be limited to this research.
- I understand that I will not be identified by name in the final product.
- I am aware that all records will be kept confidential in the secure place.
- I acknowledge that the contact information of the researcher, Merih Fidan.
- I understand that the data I will provide will not be passed onto any third part.
- I understand that I may withdraw from the study at any time.

Participant's Name: (Optional) _____

Participant's Signature: _____

Date: _____

Appendix 22 : In-depth Interview Consent Form: Counsellors

Informed Consent

Investigation of the experiences of clients, counsellors and interpreters in a triadic therapeutic relationship.

The Researcher: My name is Merih Fidan, and I am a PhD student in the Institution of Lifelong Learning in Leicester University. I am conducting a qualitative research on interpreters, therapists and clients under the supervision of Prof Sue Wheeler.

The Research: The purpose of the study is to gain insight into the triadic relationship between the client, the interpreter and the counsellor. The study's findings will contribute to the academia, the interpreting sector, and the mental health service provisions.

The Process: Your participation will involve joining an in-depth interview with the researcher. The in-depth interviews last between 45 and 60 minutes. The session will be tape recorded.

Preparation: You do not have to prepare anything. Willingness to share will be enough.

Risk: The study will not pose any risk to you. I will do my best to ensure confidentiality. **YOU WILL NOT BE IDENTIFYABLE IN THE STUDY.** You can withdraw from the study at any time, and may also request that any data collected from you not be used in the study.

*By signing below you agree that you have read and understood the above information, and would be interested in participating in this study.

- I agree to participate in this study that will be a part of the fulfilment of the requirements for the PhD degree at the Lifelong Learning Institution in Leicester University.
- I understand that my participation is voluntary.
- I understand that the data collected will be limited to this research.
- I understand that I will not be identified by name in the final product.
- I am aware that all records will be kept confidential in the secure place.
- I acknowledge that the contact information of the researcher, Merih Fidan.
- I understand that the data I will provide will not be passed onto any third part.
- I understand that I may withdraw from the study at any time.

Participant's Name: (Optional) _____

Participant's Signature: _____

Date: _____

Appendix 23 : Ethical Approval Form: In-depth Interviews with Interpreters and Counsellors

University of Leicester Ethics Review Sign Off Document



To: MERIH FIDAN

Subject: Ethical Application Ref: mf151-d9ee

(Please quote this ref on all correspondence)

23/03/2011 10:10:08

Institute of LifeLong Learning

Project Title: Investigation of the experiences of counsellors, clients, and interpreters in a triadic therapeutic relationship.

Thank you for submitting your application which has been considered.

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

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

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

- <http://www2.le.ac.uk/institution/committees/research-ethics/code-of-practice>
- <http://www.le.ac.uk/safety/>

Appendix 24 : Ethical Approval Form: In-depth Interviews for Clients



Institute of Lifelong Learning Research Ethics Review Approval Form
Name of student/researcher: Merih Fidan
Course title:
Title of research: An investigation of the experiences of the therapeutic relationships between the client, counsellor and interpreter within the triadic framework of therapy.
Contact details: mf151@le.ac.uk
Status (please tick as appropriate): Undergraduate <input type="checkbox"/> Postgraduate <input type="checkbox"/> Researcher <input checked="" type="checkbox"/> Staff <input type="checkbox"/>
Name of supervisor: <i>(For office use only)</i> Sue Wheeler
Course director: <i>(For office use only)</i> n/a
I am pleased to confirm that I have read the research proposal and I consider the researcher has considered all the research ethics and has answered the relevant questions satisfactorily.
Professor John Benyon <i>Institute of Lifelong Learning</i> <i>Research Ethics Officer</i> <div style="float: right; text-align: right;"> </div>
Date: 11-3-2013

FOR OFFICE USE ONLY

- Decision sent to student
- Supervisor notified
- Filed

Appendix 25 : Clients' Answers to the Questionnaire Questions.

Table of the answers of the clients to the questionnaire questions.			
Questions asked	The responses of the clients (Out of nine participants, some did not answer)		
Number of clients found counselling as helpful.	6: Mostly	1: Not sure	
Number of clients felt understood by their counsellors.	5: Usually	1: Definitely not	3: Sometimes
Counsellor performing differently if interpreter is absent:	4: NO	5: YES	
Confidentiality was respected?	9 : YES	0: NO	
Were you familiar with the interpreter	3 :YES	6: NO	
Did you wish to see the interpreter after the sessions?	5 : NO	1: Not sure	
Who had the control of the sessions?	5 : Counsellors	3: Interpreters	1: Depends
Was the interpreter judgemental to you?	7 : NO	1: YES	1: Sometimes
Was the counsellor judgemental to you?	7: NO	1: YES	1: Not sure
Were able to talk freely when interpreter is present	6: YES	3: NO	
Couldn't say everything because of the interpreter's presence	5: YES	4: NO	
Was the interpreter sympathetic to you?	6: YES	1: NO	1: Sometimes
Was the counsellor sympathetic to you?	6: YES		2: Sometimes

Professionalism of the interpreter?				7: YES			2: NO			
Professionalism of the counsellor?				8: YES			1: NO			
Bothered by the gender of the interpreter?				7: YES			2: NO			
Bothered by the gender of the counsellor?				2: YES			8: NO			
What factors influence your relationship with the interpreter?	Being professional	Being trustworthy	Being confident	How they speak	Linguistic skills	How they treat me	Consistent attendance	How they look	Political / Religious views	Ethnic background
	9	9	9	8	8	8	7	5	4	2
Most rated influencing factors of the relationship between clients and interpreters:							TRUSTWORTHINESS, PROFESSIONALISM and CONFIDENCE of the interpreter.			
Other influencing factors			Personality of the interpreter				Being student			

Rates of the clients of the quality of the communication they had with counsellors and interpreters		
The quality of the clients' communication with the		
Interpreters	as hardly open and friendly	8 out of 9
Interpreters	as highly closed	3 out of 9
Interpreters	as relaxed most of the time	7 out of 9
Interpreters	as trustable most of the time	5 out of 9
Interpreters	as highly tense and uncomfortable	1 out of 9
Interpreters	as highly suspicious	2 out of 9
Counsellors	as relaxed most of the time	4 out of 9
Counsellors	as trustable most of the time	6 out of 9
Counsellors	as highly tense and uncomfortable	1 out of 9
Counsellors	as highly suspicious	2 out of 9
counsellors and interpreters	as open and friendly most of the time	8 out of 9
counsellors and interpreters	as relaxed most of the time	3 out of 9
counsellors and interpreters	as trustable most of the time	4 out of 9
counsellors and interpreters	as highly closed	2 out of 9
counsellors and interpreters	as highly tense and uncomfortable	1 out of 9
counsellors and interpreters	as highly suspicious	1 out of 9

Any hindering factors experienced in the relationship? ³¹	With counsellors: Yes= 1 out of 9 No= 8 out of 9	With interpreters: Yes: 3 out of 9 No= 6 out of 9
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³¹ All this information was used and integrated in the relevant chapters.

Appendix 26 : Dissemination of the Research Findings

To be presented as

Paper

- The Elephant in the room! Society for Psychotherapy Research Conference. Oxford, UK. September -2017
- Research Conference of British Association for Counselling and Psychotherapy, 2018.
- Annual Conference of British Psychological Society, 2018.
- Institute of Interpreting and Translation Conference, 2018.

Oral and Poster presentations

- 3-minute PhD presentation competition. Leicester University. May 2017.
- Midlands ESCR student Conference. University of Birmingham. June 2017.

Previously contributed oral presentations and posters

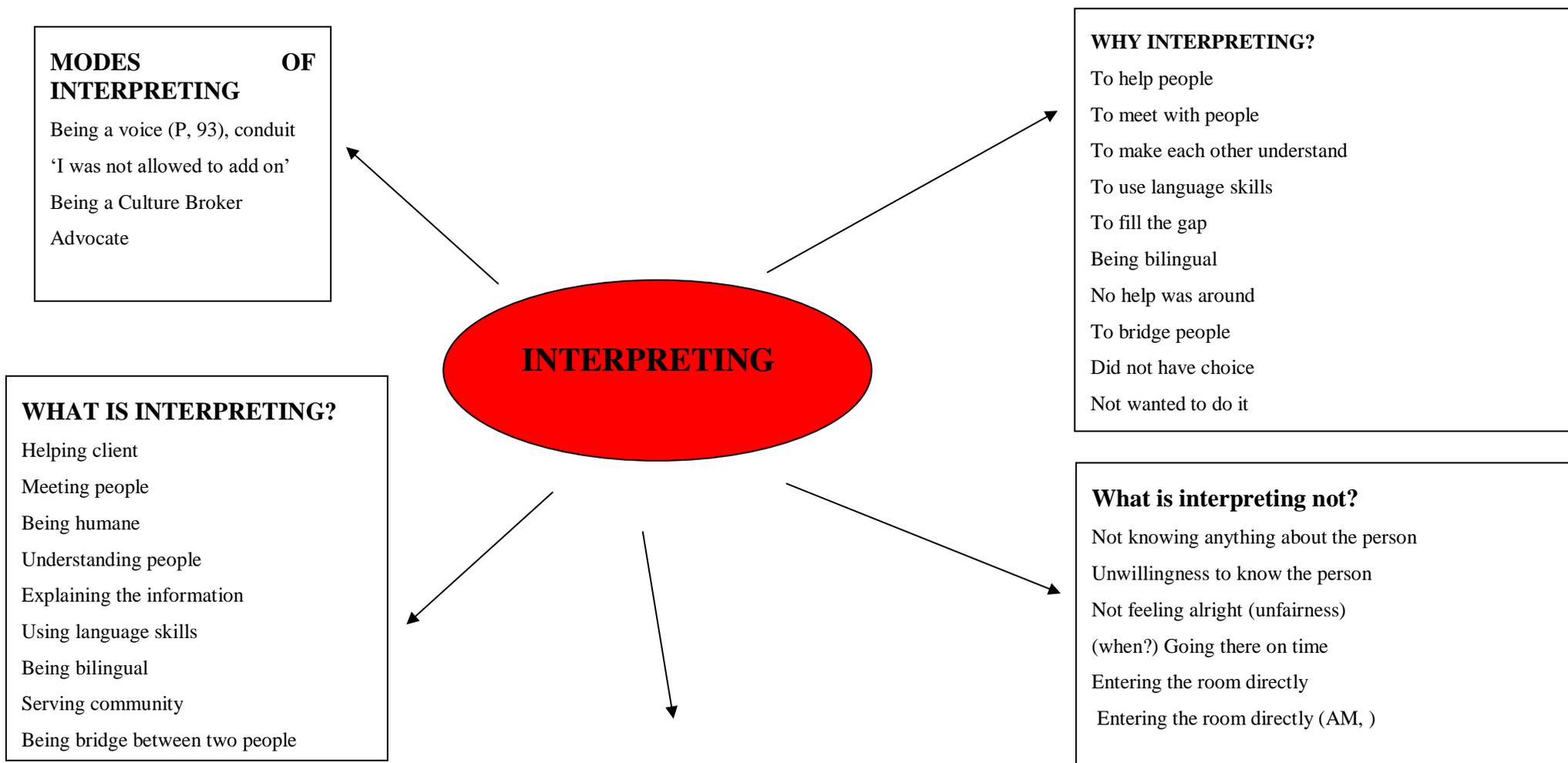
- The impact of critical thinking on mental health. 1st International Critical and Analytical Thinking Symposium. Sakarya University. Turkey. April 2015.
- ‘Make me a match! Clients’ experiences of counselling through interpreters’. Society of Psychotherapies and Research. 25-28 June 2014. Copenhagen, Denmark
- ‘The importance of amalgamating inter-professional education to the higher education curriculum in Turkey’. Journal of Higher Education. February 2014.
- A comparative investigation of experiences of interpreters and counsellors in working with non-English speaking clients in triadic frame of therapy. Birckbeck College. London. Bloomsbury Round Table Seminars. June 2013
- What matters for counsellors working with interpreters in therapeutic settings?
Institute of Lifelong Learning. Leicester. May 2012.

- What matters for counsellors working with interpreters in therapeutic settings?
COSCA. 8th Counselling Research Dialogue. Stirling. November 2011.
- What matters for counsellors working with language interpreters?
BACP Research conference. Liverpool. May 2011.
- Interpreters' making sense of interpreting in psychotherapeutic settings.
Research Festival. University of Leicester. 24 June 2010.
- 'Mental health needs of asylum seeker men.'
Annual Conference. Counselling Psychology. Warwick University. July 2009.

Conferences and workshops attended

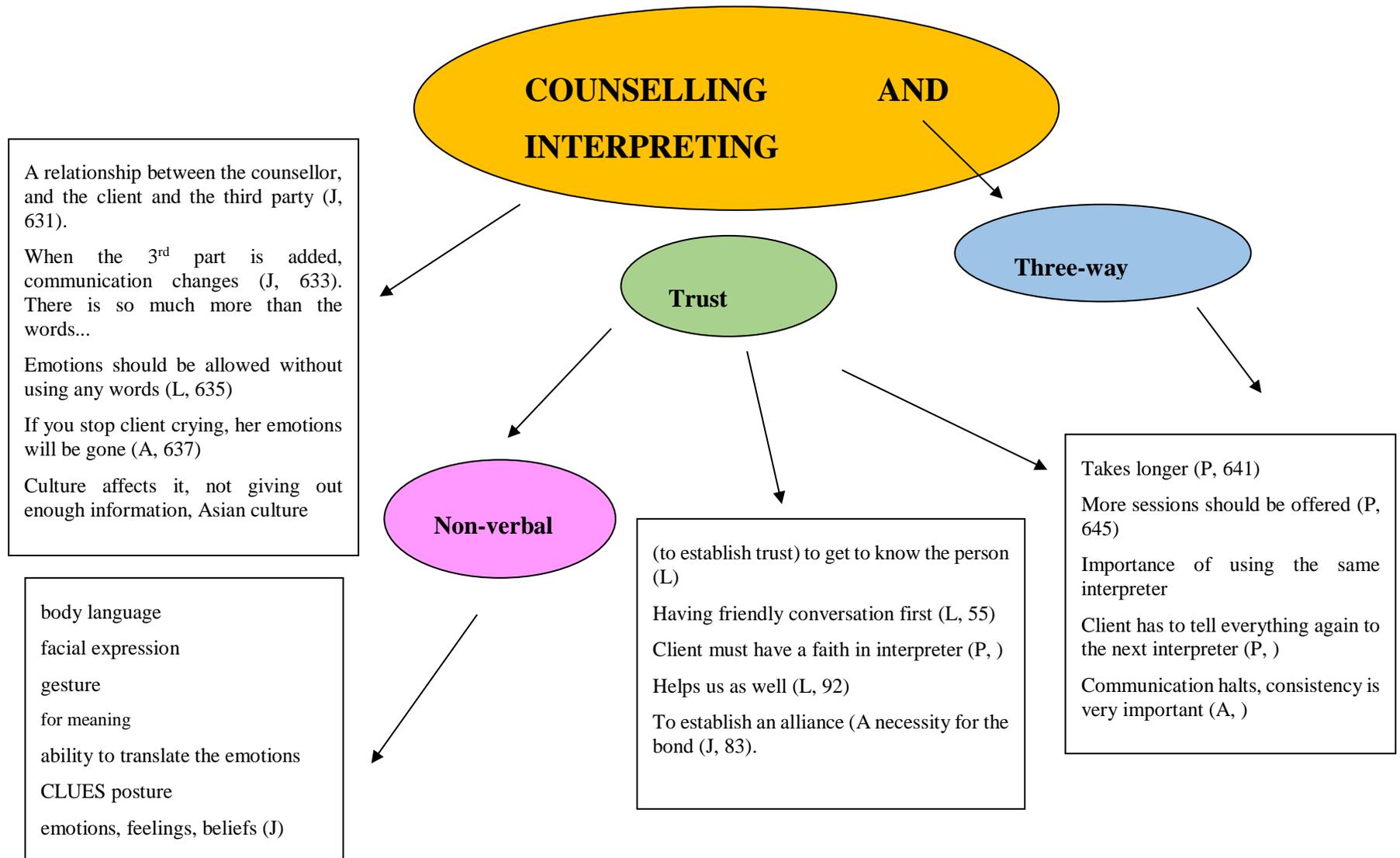
- Ethical considerations and critical thinking in Bio-health medicine and finance.
University of Oxford. February 2017.
- Interpreting and Translation Institution, West Midlands Group.
Aston University, Birmingham. June 2015.
- Inter-Professional Education, REVIEW. Centre for Advancement in Inter-
Professional Education. November 2014. London.
- Critical Thinking in practice. Critical Analytic Thinking Academy.
April 2014. Ankara, Turkey.
- 'Interpreters training programme.' Interpreting at Leicester. 2013.
- How to enhance critical thinking. Community Seminar Series. Leicester. 2012
- Mental Health Interpreting. Mother-tongue (Multi Ethnic Counselling
Organisation). Reading. June 2011

Appendix 27: One of the Working Thematic Maps. (The Interpreters' data).



**WHAT
DOES
COUNSELLING
INVOLVE?**

Interpreting emotions, beliefs, feelings, stories (J, 83,84, AM89)
Having bond with clients (J, 83)
Involving yourself (AM, 87; L344; AM 349)
Be his word even he is stressed. (Am, 87)
Not adding anything to what clients says (P, 93) (MF, conduit interpreting)
Dealing with emotional stuff (AM, 88)
Being there of time (AM, 262)
Having multiple bookings, causing them to rush (AM,
Not focusing on the names of clients (AM, 212)
Sometimes doing other people's job, e.g, receptionist (AM,
Acting in multiple roles /Advocating
Dealing with stress (P, 228; AM, 229)
A human activity, human being/ not machine/not fly/not a bird
Driving long distance, 50 min. (P, 291)
Time consuming issues like getting up, dressed, being out in the traffic,
P
Witnessing upsetting conditions, 3rd degree burn, absence of organs, P
Knowing the client through repeated bookings (AM, 344)
Acting with instinct (J &AM 368)
interpreting may involve interpreting unexpected words ('I am a thief')
(AM)



HOW TO ESTABLISH THE TRUST AND FAITH

FAITH
Speaking the same dialect with the client (P, 77; J, 109)
Extending the mode of interpreting to culture broker etc
Client having faith in interpreters a prior.

POTENTIAL

TRUST:
Having friendly conversation first (L, 55)
To establish an alliance (A necessity for the bond (J,
interpreting emotions, beliefs and their story.
Taking diff approach to interpreting, (P 473)
going there earlier
seeing the person face to face
open-up the client by chatting with them
information about the person on
how they have been here, L, 53
about their family, L54

Having busy schedule, (P, 64)
Running from job to job. (P, 65)
Mismatch (MF) client say but, actually, not speak the language (P, 76)
Institutional matters, not giving you enough time (AM, 151, 158)
External problems: transportation, no bus (AM 265)
Gender issues, men cannot ask everything, to women (AM, 458, 463; AM 459)
The mode of interpreting (MF), client asks interpreters questions out of curiosity, but doctor don't like it.