The British Psychological Society

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Working with interpreters: Guidelines for psychologists

November 2017

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Preface

In today's multilingual and globalised world, it is likely that psychologists will come into contact with service users who do not use English as their first language, or who use British Sign Language (BSL) Interpreters. This will happen whether working with adults, children or young people, in the UK or overseas settings. All parties, including commissioners, need to facilitate clear pathways to support for all members of their local community including those who speak another language. To ensure that all groups have access to psychological services and that the outcomes of such services are equally effective, psychologists may have to work with interpreters. These good practice guidelines give an overview of the issues that psychologists need to consider when working with interpreters to ensure that they are able to be as effective as possible.

Prepared by Professor Rachel Tribe, University of East London & Dr Kate Thompson, InterHealth Worldwide with acknowledgement to the Glasgow Psychological Trauma Service, DCP Faculty for people with intellectual disabilities, Neuro-psychology colleagues particularly the group representing BSL/English interpreters who responded to the consultation. With thanks to Dr Farkhondeh Farsimadan for her attention to detail and proof reading skills.

Key recommendations for practice

Psychologists should:

- Consider undertaking a language needs analysis for the service population and consider how to best meet identified needs.
- Consider undertaking a training course in working with interpreters or, if working with an interpreter unexpectedly, read the guidelines and allocate time to consider the issues or discuss them with a more experienced colleague prior to your first session with an interpreter.
- Consider attending a d/Deaf[1] awareness training in advance of working with a Registered Sign Language Interpreter (RSLI).
- Check the interpreter is qualified and appropriate for the consultation/meeting
- Allocate 10–15 minutes in advance of the session to brief the interpreter about the purpose of the meeting and to enable them to explain any cultural issues that may have bearing on the session.
- Be mindful of issues of confidentiality and trust, when working with someone from a small language community (including the d/Deaf community). The service user may be anxious about being identifiable and may mistrust the interpreter's professionalism and the psychologists may need to address this directly.
- Consider matching service user and interpreter for age, gender and ethnicity and should discuss this in advance with service users so that their preferences can be taken into account rather than assumed.
- State clearly that they alone hold clinical or organisational responsibility for the meeting
- Create a good atmosphere where each member of the group feels able to ask for clarification if anything is unclear.
- Commit to a collaborative, working relationship based on trust and mutual respect across all parties.
- Be aware of the wellbeing of the interpreter and mindful of the risk of vicarious traumatisation. Consider what support they will be offered, and if they are subcontracted from an outside agency be aware that there is often little support provided by their employer.
- Allocate 10–15 minutes at the end of the session to debrief the interpreter about the session and offer support and supervision as appropriate.
- Ensure that all written translations used have been back translated to ensure they are fit for purpose.
- Exercise extreme caution when considering the use of translated assessment measures.
- When employing simultaneous interpreting, consider the additional concentration necessary and include regular breaks where possible.
- Be aware that meetings conducted with an interpreter may take longer and take account of this when booking appointments.

1 The use of the small 'd' deaf is used to signify that the person primarily identifies with hearing people despite experiencing hearing difficulties. In contrast, using a big 'D' suggests that the person tends to identify themselves as culturally deaf and have a strong Deaf identity.

- Use their often unique positions in different organisations to advise on best practice when working with interpreters.
- Offer an interpreter in situations where one family member has good English but others do not.

Introduction

As a general principle, it is the responsibility of the psychologist to ensure effective communication between themselves and service users. The British Psychological Society is committed to equality and inclusion and recognises that it is fundamental to avoid discrimination by ensuring equal access to psychological services for non-English speakers, including those who use sign language. Although working with an interpreter and having to communicate through a third person can feel like a challenge (and may require professional development) there can be definite gains in developing skills in this area. For example, working with an interpreter can expand knowledge of variations in psychological wellbeing, idioms of distress, explanatory health beliefs and world views[1].

There is clear evidence of the value of psychological therapy for those who are not fluent in the language of the country in which they live. Research with refugees who have experienced trauma indicates that the outcome of psychotherapy mediated by an experienced and professional interpreter is equal to that undertaken with direct communication[2, 3]. On the other hand, numerous health related studies show that quality of care can be affected negatively when service users with little host-language proficiency require, but are not provided with interpreters[4, 5].

Overall, the failure to use an interpreter can lead to significant difficulties and additional costs in the long-term (see East of England Commissioning Framework for Language Support[6], for a helpful discussion of all the issues caused by inadequate language support, pp.7–12).

Language is a multifaceted, rich and complex phenomenon, which forms one of the cornerstones of human communication and should be accorded particular attention in providing psychological services. Trained interpreters are often not recognised for the unique skills and expertise that they can contribute, enabling psychologists and clients/service users to communicate with, and understand one another. It is through language that psychologists collect and analyse the data that then informs their intervention. Working with d/Deaf service users who use sign language as their first language, likewise requires specialist skills due to the need to consider a visual language rather than a spoken language [7, 8]. The d/Deaf community often have poor access to mainstream mental health services and common mental health problems are reported to be higher in the d/Deaf community[9].

The exact relationship between language and meaning is still contested. Many theorists argue that language not only transmits meaning but also constructs and shapes it at the individual and societal level[10, 11] and this should be kept in mind when working with an interpreter. The psychological relationship between a person and their first language and a second or subsequent language is also an area of debate[12, 13]. Paradis[14] in a review, notes that a range of indicators which might be defined as psychotic (including auditory hallucinations, delusions, conceptual disorganisation, anxiety, and depression) have been found to affect service users' differentially; sometimes being evident in first languages only, sometimes in second or subsequent languages and sometimes in all the languages spoken by a service user. There is more work needed to consider the complexity of this relationship.

It is important to recognise that linguistic and cultural dynamics are different working with BSL users when compared to working across two languages. We would recommend seeking specialist advice when undertaking such work in addition to the information in these guidelines.

These good practice guidelines provide some working principles to help inform and direct practice. They do not, however, attempt to cover every eventuality that may occur when working with an interpreter. The Society expects that the guidelines will be used to form a basis for consideration, with the principles being taken into account in the process of making decisions, together with the needs of others and the specific circumstances. No guidance can replace the need for psychologists to use their own professional judgement. Psychologists should refer to these guidelines in conjunction with the underlying BPS practice and ethical guidelines.

1. Relevant legislation and policy

There is extensive international and national legislation that advocates for equality of access to education, health and social care services. Legal frameworks that advocate for equality of access to such services include:

- European Convention on Human Rights (1952).
- The United Nations Convention of the Rights of the Child (1989).
- Human Rights Act (1998).
- The Equality Act (2010).
- The Mental Health Act 1983: Code of Practice (2015).
- BSL Act (Scotland) (2015).

Many organisations will have their own policies relating to equality of access to services possibly including the use of interpreters. Psychologists should ensure they check any local policies for guidance.

2. Choosing an interpreter

2.1 Language needs analysis

Psychological service providers may need to consider conducting a formal needs assessment relating to interpreting services. This analysis should be undertaken at the service level, although individual psychologists have a responsibility to monitor and inform service leads about the characteristics of their service users.

This might include:

- Obtaining base line data on the language needs of the communities they serve, including British Sign Language (BSL), and a review of the languages used by relevant staff to ensure that they make optimal use of the language resources they have available[6]. Although as discussed in 2.2 below this in itself raises a number of issues.
- Considering whether the needs of their population are best served by employing interpreters; bilingual link workers who link a local statutory service with a community; or advocates, who support the individual by ensuring that their needs are understood. Further information on BSL advocates can be obtained from the British Deaf Association[15] or from the National Registers of Communication Professionals working with Deaf and Deafblind people[16].
- Considering whether to employ directly or use external interpreting services.

2.2 Locating an appropriate interpreter

It is the responsibility of the service provider to find out the service user's first language and try and book an interpreter who speaks this language, ideally from the same country, and when necessary a speaker of the same dialect as the service user. It should not be assumed that someone who speaks a language can speak/understand it in all the dialects[17, 18]. A guide to languages by country is at https://www.ethnologue.com/ In addition, it is widely recognised as good practice to maintain the same interpreter when undertaking therapeutic work. As this can have implications for resources it is important to be mindful of this.

When choosing an interpreter to work with a family, it is important to ensure that the language chosen is understood by ***all*** members of the family[19]. Depending on the setting, the psychologist should also consider that certain conditions, for example dementia or intellectual disabilities can diminish the ability to speak a second language[20].

The interpreter should be (not only) fluent in two languages but also should have an understanding of the two different cultural contexts [21, 22]. Ideally they should have undergone recognised language testing to ensure that they are fluent and have relevant experience for the task. In Britain, the Register of Public Service Interpreters[23] and the Institute of Linguists[24]; can assist in locating a suitably qualified interpreter.

In the case of d/Deaf service users, it is important to ensure that the interpreter is on the

National Registers of Communication Professionals working with Deaf and Deafblind People[25] . They may also have a Signature[26] accredited BSL qualification, be registered with the Association of Sign Language Interpreters (ASLI)[27] or the Scottish Association of Sign Language Interpreters (www.sasli.org.uk). Action on Hearing Loss[28], formerly the RNID can also offer support in finding a sign language interpreter for d/Deaf individuals.

Fluency in sign language is very variable. Some d/Deaf people, and perhaps a high proportion of those needing mental health support, including those with intellectual disabilities, may not be fluent in sign language due to the delay or lack of opportunities to learn BSL and/or written English, or due to their underlying intellectual disabilities. Educationalists have often promoted an 'oral' approach to d/Deaf education, and this has prevented d/Deaf children from learning to sign because of the belief that this will interfere with their ability to learn spoken and/or written language. In reality, many d/Deaf children have been drawn to signing as a natural method of communication. Others may not have had this opportunity at school and have consequently learnt BSL as an adult, perhaps through attending a d/Deaf Club. For some d/Deaf people, then, signing may be not fluent, but this may only be an indication of their particular situation rather than an intellectual disability or a mental health difficulty. A thorough assessment of fluency prior to any psychological intervention is likely to be helpful.

It may be useful to consider working with a d/Deaf BSL/English interpreter or relay interpreter, as well as a sign language interpreter if the service user's sign language is dysfluent through any significant language delay during childhood or an actual intellectual disability. A d/Deaf interpreter who is a fluent BSL user is likely to bring additional experience of communicating effectively with a variety of d/Deaf people with varying levels of language ability being able to break down complex signed phrases into simpler ones enabling a d/Deaf service user to understand the concepts being discussed. Working in this way will change the dynamics in the room as another person is put into the chain of communication between the psychologist and the service user. However, this may benefit the service user who may feel more comfortable with another d/Deaf person in the room helping them to be more effectively involved in the communication. This can balance the cultural identities and power differentials in the room with two hearing people and two d/Deaf people.

Inviting service users to attend sessions with other people who might aid their communication abilities might be helpful, for example service users with intellectual disabilities, aphasia or dysarthria might benefit from attending sessions with a support worker who is more familiar with their style of communication and can offer clarity to the psychologist.

As a general rule, it is not appropriate to ask family members or other professionals to 'help out' because they appear to speak the same language as the service user or have sign language skills. Interpreting is a highly skilled role and not something that any person or even any professional can just slip into[8, 29, 30, 31].

Similarly, bilingual staff are not automatically qualified to act as interpreters despite their professional experience and ability to speak two or more languages. If they do wish to act as an interpreter they should have their language competency level assessed and their interpreting skills verified before they are permitted to interpret for service users.

In cases that bilingual staff are used as interpreters, this should be valued as a separate and additional skill, and staff should be recognised for offering this service, and offered support with continuing professional development to maintain and improve this role.

The use of family members also creates difficulties with regard to confidentiality (see above) [32,33]. Some service users may insist upon using a family member to interpret for them and in this case, their choice should be discussed with them (and with other family members if appropriate). Before agreeing to this, professionals should be aware of the limitations of working in this way. The use of children as interpreters is rarely appropriate, as it places them in a difficult and prematurely adult role towards their parent or relative (see point 2.3).

If the service user refuses a professional interpreter and comes with a non-professional to interpret (even if this is a family member or friend), it is important to make clear to them that they can have a professional if they want, and that it is clear why they might prefer someone they know. Bear in mind in any work that is done with a non-professional that they may not be as skilled in the host language, or indeed in their native tongue and they may have little or no experience of, or training in interpreting. They may be unclear about such issues as confidentiality, boundaries and the use of good interpreting skills. It is also the case that research suggests relatives and ad hoc interpreters can subtly change meanings when interpreting, minimising a service user's symptoms or answering questions on their behalf[34]. If a non-professional interpreter is used, it is important to be mindful that the person interpreting has the power to control what is communicated, and there are potential risks (of the service user being coerced, or domestic violence or other safeguarding issues being hidden etc.). The risk of this needs to be considered carefully if the psychologist is agreeing to the use of a non-professional interpreter. Even if there is no deliberate aim to change or control what is interpreted, interpreters may have their own agenda about the service user and wish to tell the psychologist more or less about them than the service user might wish[35, 36]. Overall, it can be helpful for psychologists to make very clear that *'our policy is to use professional interpreters'* and give a clear rationale for this so that service users can make informed choices. Psychologists should also feel able to refuse to work with particular interpreters (professional or non-professional) if they have clear reasons to do so, as the interpreter is there for the interaction and both service user and psychologist should be at ease with the interpreter used.

In some cases, using a non-professional interpreter may help to establish an atmosphere of trust or set the scene for some psychological work in such a way that the psychologist can then negotiate with the service user to introduce a professional interpreter[35]. It can also allow the psychologist to explore whether the service user speaks additional languages, as they may prefer to use a second or third language interpreter if they are concerned about confidentiality in their first language community. Miletic et al.[19] suggest for example that Somali service users may speak Arabic or Italian and feel more at ease working in either of these languages with an interpreter. In all cases in which an interpreter is required but is either refused or is not available, the reason for this should be documented in service user notes.

In many cases individuals may come from small ethnic communities and as a result their interpreter may be known to them from other settings. This can create complications. In the case of d/Deaf individuals, the d/Deaf world is a small one (about 87,000 d/Deaf

BSL users in Britain) and the sign language interpreter population is even smaller (about 900 registered in Britain) making it quite possible that an interpreter has interpreted for any given service user before. In both language and sign language interpreting work, this familiarity may be acceptable (or even preferred) by the service user. However, it is always important to explore whether the service user and interpreter know each other and whether there are concerns about the level of confidential information that may require to be shared.

Some writers have suggested that it can be helpful when possible to match for gender, age and religion between language interpreters and service users[37]. This can be particularly relevant, for example, in situations involving sexual assault or domestic violence or when discussion of taboo areas may be necessary. When a woman/girl is a survivor of gender based violence a female interpreter should usually be booked as a matter of course. When working with asylum seekers or refugees it is important to be cognisant of the wider politics and subsequent choice of interpreter, for example, if seeing a Chechen service user it may be better to book a Chechen or English interpreter who speaks Russian rather than a native Russian speaker, otherwise a service user may not feel able to speak as openly as they might. Further information is available in Society document: *Guidelines for psychologists working with refugees and asylum seekers in the UK.*

However, service users can differ in their requirements and it is important to offer a choice and assess individual needs. This can readily be done at the same time as asking the service user about what language would be most suitable for them, perhaps by sending an easily completed form with their initial appointment letter. It should also be acknowledged that while offering a choice may be the ideal, it is not always possible to ensure this.

2.3 Child Language Brokers in Educational Psychology

Some psychologists have advocated for the use of Child Language Brokers in Educational Psychology. Child Language Brokers (CLB) assume a mediator role between their own family and other parties, most notably their school in order to gain access to information, resources and opportunities in a setting in which other members of the family do not speak the language fluently. The results of CLB are mixed and psychologists who have argued for their use often do so with specific provisos[38, 39]. Overall this is a contested area and the employment of qualified interpreters is likely to offer a better, more professional, if more costly alternative.

2.4 Telephone interpreting

> *'Telephone interpreting is a three way conference call that connects an interpreter via telephone to individuals who wish to speak to each other but do not share a common language. The telephone interpreter converts the spoken language from one language to another, enabling listeners and speakers to understand each other.'* [40]

There is sometimes pressure on psychologists to use telephone interpreting which some assume to be easier to manage, quicker or cheaper. While it may have a role, it is not without its own dilemmas and often does not make things any less costly. Most interpreting agencies charge by the minute or for a number of minutes for telephone interpreting

and by the hour for face-to-face interpreting, making telephone interpreting far more expensive for longer contacts.

In some cases it can be helpful to use a telephone interpreter. For example, one advantage is that confidentiality is safeguarded to a higher degree when the interpreter and service user do not meet face-to-face. This may be helpful when the service user comes from an ethnic group which is very small or they are embarrassed about needing an interpreter or have an issue which they have difficulty expressing. It can also be helpful for rearranging appointments or other forms of negotiation when face-to-face interpreters are unable to attend for any reason. A further instance can be when a service user arrives unexpectedly and requires a brief consultation or perhaps an immediate risk assessment, or where the need for conveying test results is necessary. The equivalent of telephone interpreting for d/Deaf service users, video remote interpreting services, can be accessed online.

In the main, however, as stated above, psychological work with its complex and relational setting is better conducted with a face-to-face interpreter, who like the psychologist, would use the non-verbal communication of the service user as a vital part of what they are able to feedback. It is even less likely to be appropriate where service users present with added communication difficulties (for example due to underlying intellectual disabilities).

Whenever interpreting by telephone is used, a recognised and accredited agency should be employed as provider (see section 2.2).

2.5 Written translations

All written translations should be back-translated. This refers to the process of taking a translated passage or text and re-translating it back to its original language in order to verify its meaning. The two passages (pre translation and post back translation) can then be compared for concordance of meaning. This can appear a costly and time-consuming business, but can ensure that the translation is clear and states what it is intended to state. There have been many examples of incorrect and sometimes incomprehensible translated versions of English documents, and it is well worth the additional effort of further checks to ensure the message is adequately translated. This may be particularly important when assessment and/or therapy has occurred and is being reported as a legal case. Written translations should also take account of any underlying intellectual disabilities for the service uers, and provide written or pictorial information in the form likely to be most meaningful for them.

In clinical settings, written care plans should be available in the service user's own language and care should be taken to ensure accurate translation. When providing written information for d/Deaf people (including care plans) be aware that not all d/Deaf people are comfortable with written language. However, there is no alternative written form for BSL. The psychologist may need to be creative and use video or DVD to record a signed version of a care plan.

3. Considerations and preparation before the consultation/meeting

The psychologist should spend some time considering all the implications of working with an additional person (the language or sign language interpreter) before the consultation/meeting. It can be useful to discuss this with an experienced interpreter or failing that with colleagues who have experience of working with interpreters.

The service provider should have written guidelines and a contract that interpreters are asked to adhere to and ideally sign. The psychologist may need to ensure that their interpreter signs the contract of their organisation. This should cover such aspects as confidentiality, roles, responsibilities, ethics and boundaries. For example, it is important that the service user maintains self-determination in the same way as any other service user. All parties should ensure that this is not compromised by an interpreter being involved. In the case of Registered Sign Language interpreters, there is an established code of conduct, which provides guidelines for dealing with ethical issues. However, these guidelines may not include some of the challenging situations that can occur in psychological work.

It is also important to ensure that an interpreter is fully aware of all issues relating to professional boundaries in the setting in which they are working. For example, in some settings it is preferable if an interpreter involved in ongoing work does not interpret for the same service user in other situations. If this is the case, the interpreter should be fully briefed and allowed to discuss this requirement with the psychologist, so that there is clarity about expectations.

3.1 Training

It is argued that the provision of appropriate training for both practitioners and interpreters, as well as the use of effective guidelines can produce improvements in service provision[41]. More experienced interpreters tend to recognise this need, and are more likely to advocate training both for themselves and for the professionals for whom they interpret[42]. Baker et al.[43] note that the same applies to BSL interpreters, although training for professionals working with BSL interpreters has not yet been established. Further, many of the difficulties described when working with language interpreters in education, health and social care settings seem to arise as a result of inadequate training for both parties. Tribe & Raval[21] provide a template for a possible training curriculum.

Both interpreters and psychologists require appropriate induction in working together even if an outside agency is providing interpreters. Running appropriate training and information sessions ensures that the interpreters are conversant with the organisation's aims, objectives and culture and may also provide an integrating function[44, 45, 46]. Joint sessions when professionals and interpreters are trained together allow a better understanding of each person's role as well as the development of a genuine sense of co-working.

It is recommended that clinicians working with interpreters seek out supervisors with appropriate experience. In some cases, a bilingual supervisor may make a key contribution to the clinical team[47]. It has been argued that working in second or subsequent languages

without adequate bilingual supervision (and by extension working with interpreters) is ethically unsound and it is important to consider any risks that this might pose[47, 48].

It is recommended that each psychologist takes individual responsibility for ensuring they are skilled at working with interpreters. Lack of experience or skills should not be used to justify not engaging in psychological work via interpreter. No psychologist should be in a position in which they cannot offer equity of service to all potential referrals.

3.2 Changes to the dynamics in interpreter mediated relationships

A service user may have concerns about having to depend on someone else, the interpreter, to act as their voice and to explain their emotions. Some service users have reported feeling infantilised by this process[49] and this compounded with concerns about trust and confidentiality may create tensions in the working relationship. Alexander et al.[50] have noted that the issue of personal trust is seen as paramount by service users. A psychologist working with an interpreter needs to be aware of this, and to consider how this may impact on their work.

Working with an interpreter as a conduit also makes the practitioner dependent on someone else and this can be unsettling. Practitioners sometimes report feeling anxious in this situation or excluded from the interaction, which can feel as though it takes place mainly between the service user(s) and the interpreter. Some authors working in clinical settings have noted difficulties with exploring negative feelings in therapy when working in three way relationships[51] and it may be that these more unstable dynamics make this more challenging.

There can be a sense of two or more overlapping dyads, for example the practitioner and interpreter (who share one language and perhaps a position of relative power), or the interpreter and service user (who share another language and perhaps some common experience). As a result, it may require more time to establish a good three-way therapeutic relationship[52].

In the case of Registered Sign Language interpreters, it is useful to remember that the interpreter is a hearing person like the majority of psychologists. This may affect the dynamics within the room as there will be two hearing people (with privileged positions in a dominant hearing society) and one d/Deaf person (with a less privileged position and frequent experiences of being excluded by hearing people). Most interpreters will have some awareness of this dynamic, but it is important to reflect on the interactions within the session. Likewise, it is also possible that the service user will be suspicious of all hearing people, and maybe sign language interpreters in particular, perhaps accepting them only as a necessary evil. There is an additional dynamic of perceived alliance between d/Deaf people and interpreters on the part of health professionals, who may see them as sharing a common language and understanding of d/Deaf culture.

The best way to manage such developments is to reflect upon them, both in supervision where possible (for the psychologist) and in conversation with the interpreter, who may be able to feed back other aspects of the dynamics and may need help in managing or containing these.

3.3 Language and culture

Oquendo[53] notes that cultural nuances may be encoded in language in ways that are not readily conveyed in translation. In general, the languages being used need to be thought about and it can be helpful to discuss these issues with native speakers, including the interpreter, in advance of the meeting. This also makes sense when considering the use of non manual components of British Sign Language (e.g. facial expressions, body movements, etc.) and bringing reflections on this into the consideration of the psychological process of work.

Similarly, it is helpful to remember that languages are not directly interchangeable; meanings may be coded, emotionally processed and internalised in one language and may not always be directly accessible in another[13, 54]. There may be no appropriate word in one language for terminology that is commonplace in another. Again, native speakers including the interpreter may be able to advise on this. For psychologists offering therapy, it is important to remember that, metalinguistic strategies common in therapy such as intentionally open questions or hanging sentences are nearly always entirely different in their effect or impossible in the other language as they often rely on language-specific features.

In addition, health beliefs and views about emotional wellbeing, as well as idioms of distress and manners of presentation can vary with an individual's cultural and religious background. This can have important implications which need careful handling particularly when working in either mental health or forensic/legal settings[55].

As well as the factors influencing language and culture, it must be remembered that conversation conducted using interpreters is *mediated communication*, mediated through an interpreter or through a second language[56] a process that can bring inadvertent changes. Given that interpreters must process the material with which they are dealing through their own subjective experiences, the very act of interpreting shapes the material in some way. This is a highly complex issue, and researchers have understandably encountered difficulties in trying to investigate it[17, 57, 58]. The communication can become altered through the mediation of the interpreter in numerous ways. One example might be when an interpreter takes it upon his or herself to interpret only part of what is said, summarising the gist for the practitioner[51], or alternatively when a psychologist has failed to explain the use of specific techniques or approaches making their style or choice of questioning hard to translate (for example, the use of circular questioning, reflective summarising in therapy settings). Such actions are usually an indication that the psychologist and interpreter have not had a meeting in advance of the session to clarify their roles and the stance required of the interpreter[59]. This is likely to be complicated by the point already made that absolute translation of one language to another is not possible. It is important to explore with the interpreter what it would be most appropriate to do in such instances.

3.4 Practical considerations

Additional implications of using mediated communication need to be considered prior to any meeting with a service user. For example:

- Remember the meeting may take longer when working with an interpreter and consider whether it is appropriate to allocate additional time in advance of the meeting[45, 60].
- Avoid using complicated technical language. Psychology has its own abbreviations and language, so remember that the interpreter is unlikely to have undertaken training in psychology in either of the languages used. Some medical and legal agencies find it useful to have a specialised medical or legal dictionary available[45].
- Words and signs often do not have precise equivalents across different languages, and a short sentence in English may take several sentences to explain in another language or vice versa. Do not become impatient if the interpreter takes longer to interpret than expected[18].
- Be wary of using proverbs and sayings, which may be culturally specific and impossible to interpret. If something does not make literal sense, it is usually best avoided. This said, in some cases the use of a proverb in the service user's language, or a proverb or saying in the psychologist's language, can be very powerful in illustrating an idea. This does need careful handling, however, to make sure that all parties have truly understood the meaning of the concepts used.
- Practitioners should also be aware that it can become easy to lose concentration or to lose the thread of the session as the pace becomes slower and perhaps disjointed, given the space needed for interpretation.
- As stated above, if the service user(s) will be seen for a number of sessions, the psychologist should try to use and book the same interpreter throughout to encourage rapport and build trust between service user(s), interpreter and practitioner. This will make the process flow better, contain anxiety for all participants and is likely to lead to better outcomes[34, 61]. A service user's request to change the interpreter should be explored within the work and accommodated whenever possible. Thompson and Woolf[35] suggest giving the service user a form at the end of the first session of therapy, for example, so that they can confirm whether they are happy with the interpreter. (This can be taken away and sent back afterwards). Most people can find someone to translate the form or understand a little written host-language and this allows them a say in whether to proceed with the interpreter offered. It is also possible to use a face-to-face meeting with the service user to explore these issues using another interpreter. Psychologists should know how to explain the complaints procedures of their organisation or employer in case a service user wishes to make a complaint about something related to their experience of interpreting.

Consider the layout of the room and the positioning of chairs before the session starts. In clinical settings, such as psychological therapy, a triangle usually works well as the parties are equidistant and the interpreter is accessible to both the practitioner and the service user. In some cases, however, clinicians prefer the interpreter to sit behind the service user and literally become their voice, taking a lower profile in the session[60]. Other psychologists may prefer interpreters to align physically with them, sitting slightly behind[36] or in another arrangement. While this is a matter of personal preference, it is important to be clear that wherever the interpreter sits, they are an active part of the working relationship, and cannot be considered as a simple mouthpiece. The choice of seating will also have an impact on the dynamics in the room (see section 3.1).

In sign language interpreting, it is good practice to sit next to the Registered Sign Language interpreter, and opposite the service user so that eye contact from the d/Deaf person is easily shifted between the psychologist and the interpreter. It is also sometimes helpful to position BSL interpreters so they sit behind the psychologist. Again this is something to discuss with your interpreter so that everyone is at ease with the seating arrangements. d/Deaf service users need to be able to see the interpreter at all times. The room should be well lit with few visual distractions or bright lights that can make watching signed communication (e.g. face, eyes, hands and upper body) a strain. The ASLI should be able to advise on this.

It is important to make interpreters feel at ease and ensure that they have the best opportunity to use their language skills and cultural understandings in the service of the service user[62]. The psychologist may wish to consider how they will do this. For example, at the initial meeting with an interpreter the psychologist can convey to them a willingness to listen to any suggestions or ideas they may have about the service user. This needs to be conveyed in such a way that the psychologist makes clear that they have responsibility for decisions about the service user's care, but welcome input nonetheless. A warm and supportive atmosphere between practitioner and interpreter is likely to facilitate the relationship for the good of the service user(s).

Some interpreters use the first person when interpreting (saying 'I' when responding with the service user's words) while others feel more comfortable using the third person. Some authors have suggested that it is preferable to use the first person, giving a more accurate rendition of the words and emotions being expressed and conveying a better sense of immediacy [51, 62]. In practice, most interpreters move between the first and third person, and it can be revealing to keep a check of this and reflect on what might be happening in the situation to lead to such switches. The psychologist may need to discuss any preference in advance with their interpreter and see what their stance is on this issue.

It is important to create an environment where the interpreter feels able to ask for clarification if he or she does not understand what the psychologist or service user is saying[63]. This can be encouraged through having a briefing session prior to the main meeting or consultation and leaving additional time for reflection at the end. The language interpreter is not only proficient in two languages but may be a very useful source of information about the country the service user is from, the culture, the politics, the geography, the symbols and meaning relevant to the society or to particular ethnic groups etc. It is good practice to make full use of the resource of the interpreter, something only possible if he or she is fully able to make sense of what the psychologist is trying to convey and help to create this sense in another language.

Baker et al.[43] (2008) note that this is also true to a limited extent for Registered Sign Language interpreters, noting that using the interpreter as a resource should only be done with caution. Most RSLIs are hearing people and as such do not share the Deaf culture in the same way as a d/Deaf person. If they are related to a d/Deaf person (i.e. sibling or parents are Deaf) then there may be transference issues present. The ideal, as noted by Baker et al.[43], is to use a d/Deaf relay interpreter who can provide the cultural knowledge and experience described above, which may then be discussed with the interpreter. As stated above, however, relay interpreters are not commonly used, and present an added dynamic with which the Registered Sign Language interpreter may not be familiar. Many BSL users prefer not to use relay interpreters, seeing them as 'too close' in an already close community.

3.5 Preparation with the interpreter

It is rare for interpreters to have had previous training or experience of psychological services or indeed to have worked in the same speciality as the psychologist. Wherever possible, the psychologist should aim to arrange a pre-session interview with the interpreter. The psychologist should spend ten or fifteen minutes on the first occasion to establish a relationship, decide how they will work together, explain the objectives of the meeting and to share any relevant background information. Longer may be required in certain circumstances, for example if psychometric tests are to be used. This is an essential investment. This may also be an opportunity to clarify technical concepts, vocabulary or jargon or simply make sure of the pronunciation of service user's name[64]. It can also be useful to use this time to check whether there are any cultural issues likely to bear on the situation. The psychologist can also decide what mode of interpreting is to be used, for example whether to work using the linguistic (word for word), psychotherapeutic/ constructionist, health advocate/community interpreter or the bicultural worker mode[45].

Brief definitions of these four modes are:

1. The linguistic mode: In this mode, the interpreter tries to interpret (as far as is possible) word-for-word and adopts a neutral and distanced position[60, 65].
2. The psychotherapeutic or constructionist mode: In this mode, the meaning/feeling of the words is most important, and the interpreter is primarily concerned with the meaning to be conveyed rather than word-for-word interpretation[41, 65, 66].
3. The advocate or community interpreter: In this mode, the interpreter takes the role of advocate for the service user, either at the individual or wider group or community level, and represents their interests beyond interpreting language for them[22, 65, 67, 68]. (This model would not normally be provided by BSL interpreters as the roles of advocate and interpreter for d/Deaf service users have been developed as separate roles/professions).
4. The cultural broker/bicultural worker: In this mode, the interpreter interprets not only the spoken word but also relevant cultural and contextual variables[65, 67].

Each of the above modes of interpreting has their place and will be appropriate in particular circumstances.

4. During the consultation/meeting

The service user may initially be uncomfortable with an interpreter being present, perhaps because of concerns about confidentiality, or simple embarrassment. It may help to explain at the beginning of the first meeting that the interpreter is a professional doing their job, has no decision-making powers and is bound by the confidentiality policy of the agency and their professional body. The psychologist may also wish to explain the limits of confidentiality that relate to their place of work, for example the need to report active suicidal ideation etc.[18]. It may be helpful to explain how the service user can let the psychologist know if they do not feel comfortable with the interpreter. It is important that psychologists actively monitor to what degree a service user appears at ease with the interpreter and follows up on any concerns.

Service users can put interpreters under considerable pressure to take on additional roles, for example becoming involved in advocacy on their behalf etc. Making clear the role of each party and the limitations of their responsibility can assist in containing such pressures[22, 45]. It is also important to try and avoid leaving the service user and interpreter alone during the session time in order to protect the interpreter from additional demands on them, and the risks of other forms of relationship developing between the two parties[19]. In cases where they wait together in a waiting room prior to appointments, it may be important to explore letting the interpreter wait elsewhere.

In therapeutic groupwork, several interpreters may be present if there are multiple languages spoken in the group. This requires careful preparation with interpreters beforehand, and management in the group context.

Look at the service user as much as feels natural, rather than at the interpreter unless speaking specifically to the interpreter. In general we tend to move our eyes in a natural way between speakers but it is important to be aware of all parties in the meeting or relationship and take care that the service user(s) does not feel excluded. When working with d/Deaf service users, it is best to maintain eye-contact with them so that communication is visually self-explanatory, although if eye contact is maintained for too long, especially during a 'silence', the d/Deaf person may feel that they are expected to talk as mentioned above. Appropriate eye contact is essential from the therapist and interpreter. The psychologist should try to resist any temptation to talk to the interpreter, unless explicitly addressing them. When the interpreter is signing, try to maintain eye-contact with the service user rather than the interpreter. It often helps to speak only when signing has stopped so that everyone is clear about who is communicating at what time. As stated above, it is important that body positioning and eye contact is used to facilitate communication as much as possible.

The psychologist may need to adjust the pace of delivery and break their speech into shorter segments, because the interpreter has to remember what has been said, translate it and then convey it to the service user. If the psychologist speaks for too long, the interpreter may be hard pressed to remember the first part of the speech. Conversely, if speaking in short bursts, speech may become fragmented and the psychologist could lose the thread of what they are saying. This also applies to the service user's speech patterns and it may be helpful to mention this to them. With open communication and trust a natural rhythm becomes established, with which everyone feels comfortable[22].

Try to avoid discussing any issues with the interpreter that do not require interpretation. This can make the service user feel uncomfortable and excluded. If such issues do require discussion, get the interpreter to explain this to the service user, or discuss these issues with the interpreter once the service user has left[22, 68]. If working with a family using an interpreter it may be helpful to clearly state that everything said in the room will be interpreted so that everyone hears and understands everything, and to ask the interpreter to interpret what is said between family members in their own language. Even if many family members speak the host language, it is important to make sure that an interpreter is always present.

Sequential interpreting is usually used in spoken language situations but not with BSL where consecutive interpretation is the norm and the pace of conversation is best left unchanged. This will of course vary depending on service users who may request a slower pace, or breaks, particularly if they have intellectual or other communication difficulties. It is also important to be aware that efficacy and accuracy of interpreter for BSL interpreters becomes much less after about 20 minutes, so scheduling breaks can be very important.

At the end of a session, a summary of what has been decided and clarification of the next steps can be useful. It can also be helpful to review the session including reflection on what the experience of having an interpreter present was like. The interpreter's views should be sought by the psychologist and also translated for the service user's benefit.

5. After the consultation/meeting

When the session is finished the psychologist may need to sign the interpreter's time sheet if they work for an external agency. Interpreters often prefer to leave after the service user so that they do not feel pressurised to get involved in a personal relationship or in helping or acting as an advocate for the service user in other situations. Showing the service user out and then signing the form can facilitate this. It also offers a structured opportunity and some time for debriefing.

The psychologist should schedule 10–15 minutes with the interpreter after the session to review how they worked together and any other issues relevant to the session (if the interpreter is being paid on a timed basis, this time must be included). This time can be used to:

- Allow time to ask the interpreter their perceptions of the meeting and check with them about anything the psychologist may have noticed in the mediated communication, for example from non-verbal behaviour or expressions.
- Ask the interpreter how the meeting was and whether anything could be usefully changed (pace of speaking, length of speaking).
- Ask them about any areas that are unclear and which their knowledge of the home country or region, or hearing of the account first hand could clarify. The psychologist can also ask about any cultural factors that may be relevant and which may have been missed.
- Do a structured debriefing if appropriate – as stated above, it may be hard for the interpreter to debrief anywhere else because of their code of confidentiality. There is often no in-house supervision for interpreters working for agencies and the psychologist may wish to provide the interpreter with some contact details in case they need to de-brief at a later stage about the session. It is important to remain mindful of the risks of distress and vicarious traumatisation that the interpreter might face[69]. In some work contexts, interpreters may be interpreting issues that they have themselves also experienced (for example seeking asylum or escaping from conflict). Psychologists need to be sensitive to this possibility.
- It may be useful when working with service users with intellectual disabilities to ask the interpreter about the extent to which the service user seemed to understand what was being said to them and whether their use of language/BSL was clear in order to try and establish the extent of any difficulties.

Individual psychologists as well as the organisations that employ them have a responsibility towards the interpreters with whom they work. Opportunities for debriefing and other forms of support must be offered whether by individual psychologists, or through other forms of intervention (e.g. supervision groups, peer mentoring etc.). It is not good practice to leave interpreters without support for their work with service users in any field of psychology. In clinical settings, it may be useful to consider whether some sort of joint supervision provision for clinicians and interpreters would be helpful. This would allow all aspects of therapy work undertaken with a given service user to be considered, as well as allowing the interpreter more scope to feed in their reflections to the ongoing process of therapy. In three-way relationships, subject

to the pushes and pulls of relational experience, the opportunity to reflect jointly may prevent some of the difficult relational processes that can arise. In any event, the use of supervisors with experience in working with interpreters should be considered for all practitioners working regularly in this way.

6. Using interpreters in specific settings (for example hospitals, psychiatric inpatient units, residential special schools and children's homes)

It is important that service users are offered interpreters when in secure settings such as inpatient units or special schools, or in safeguarding situations. Each facility should have its own protocol and procedures for implementing this. There have been occasions in the past when face-to-face interpreters were not used to the extreme detriment of the care provided. Decisions about when to contact an interpreter should be determined not only by the psychologist, but discussed with the service user and their family or carer(s). It is important to book interpreters for those who are not able to communicate in the host language, or have hearing and sight disabilities and the timing of this should be determined not simply by when it is most useful to staff (including psychologists), but also when it could be important for the service user.

Some examples might include:

- At the point of admission to an inpatient ward.
- When medication is being prescribed (informing them of the side effects, self-management – if required, and when and how to take their medication.
- Where matters that are socially or psychologically complex need to be addressed with the service users/carer (e.g. mental health, sexual health, personal information).
- When service users/carers are being assessed on a ward.
- During ward rounds. Access to telephone interpreting could also be considered at this time although this requires appropriate dual use or speaker phones.
- Consultations in which the service user cannot make a decision without full information (e.g. therapeutic options, care planning process, consent for interventions, referral to internal or external services).

In addition, it may be important to ensure that face-to-face interpreters are present from time to time simply so that the person is able to communicate with those around them while on the ward and is not left for long periods without any opportunity to speak to others. The frequency of such bookings, and the duration interpreters are to be booked for, should be determined by each unit, in concert with service users, carers and staff, but as a rough guide, it may be important to have an hour of interpreter time every 2–3 days. If this is feasible, it may be possible to explore options for shorter periods of telephone interpreting on a ward or unit, still allowing for regularity of contact.

Information in the service user's own language is important and it is good practice to use translated materials whenever possible, particularly for individuals from larger language groups. A multi-lingual appointment card or translated appointment letters may help to lower DNA (Did Not Attend) rates. BSL translation of some documents can be achieved by printing the Quick Response (QR) bar codes on documentation that links to online BSL translations.

Interpreters can also be called upon to play a role in meetings when service users' views need to be represented. In this case it is particularly important that their language skills are checked and that seating arrangements are considered to maximise the effectiveness

of consultation. It should be made clear to all the people participating in the meeting that the interpreter will interpret everything that they say and that the interpreter will represent the service user or their representative. The chair of the meeting should explain this at the beginning of the meeting.

Sometimes the need for an interpreter becomes apparent during or after a meeting, consultation or assessment has started. In these cases, the psychologist should state that they would like to contact an interpreter to understand the problem better and make contact with the interpreting provider to arrange this. In most cases engaging an interpreter will be readily compensated by a more efficient and safer consultation. Interpreters working in clinical meetings should always be treated with respect and the chair should ensure that all members of the meeting respect 'interpreter time' and do not start speaking until the previous interpretation is completed.

Some studies document a real reluctance to use professional interpreters even when it is made relatively easy to do so (for example in GP services[70]). This should be challenged on the basis of the overwhelming evidence of better outcomes when interpreters are used in health, social care and education settings. It has been argued that using an interpreter for some work can improve the way language is used with all service users[1].

Overall, it has also been shown to be advantageous when interpreters are viewed as part of a mental health team, shown appropriate collegial respect and invited to attend relevant departmental, agency or hospital meetings. Although in practice this rarely happens, it is worth considering their inclusion when appropriate, as the benefits of gaining the perspective of an interpreter or bicultural worker can be many. Interpreters can contribute to service provision and delivery and they can gain a better understanding of how organisations function and the context of the work they undertake [45, 66, 71]. It can also be helpful for interpreters to contribute directly to staff training about working with interpreters, as this builds better working relationships and sensitises staff to the issues more fully leading to benefits for all concerned.

7. Translated assessment measures

Psychologists need to be extremely cautious in the use of translated measures. In the first place, such measures may not have been adapted for the population from which the service user originates. Psychometric measures tend to have been designed with one particular group in mind and the concepts used may not be applicable to other groups. Fully adapting a measure includes back translation (see point above), measures of equivalence of construct, reliability, validity and norming. See the I*nternational Test Commission Guidelines on Test Adaptation*[72] for a full discussion of this. Rahman et al.[73] advise the use of key informant interviews and focus groups for mental health screening rather than questionnaires, which often incorporate complex conceptual and construct issues. *Neglect of adaptation procedures compromises the meaning of any results gleaned from the use of such measures*[55].

It is also important to be clear that the use of a translator or interpreter to do an on the spot interpretation of an assessment tool or measure *does not address the inherent problems* with using these types of assessments unadapted. It does not make them more culturally valid or replace proper forms of adaptation. Such 'live' translation can change the parameters of psychometric properties in ways that are difficult for the psychologist to control for.

Even when a measure or test has been adapted, and can be used or at least referred to in order to support an interpreter's translation, the test should be used with caution because some items may make assumptions about how recently the service user has been in their country of origin, or fail to account for ethnic, regional or education differences sufficiently. Any given individual varies in terms of the familiarity they have with concepts used in psychometric testing, with testing-type situations and with the degree to which they can understand the purpose of assessment. There is always a risk that the process itself and tasks appear meaningless negatively affecting the level of engagement the individual feels to the task involved.

It is not difficult to identify the multiple cultural biases within psychometric tests where normative data is primarily available for English or other host-language speaking populations. For example, different words have different frequency rates, interpretations, and difficulty levels depending on the specific language involved. It is also essential that the interpreter understands the importance of adhering to standardised instructions, e.g. restrictions on paraphrasing and repetition, which are particularly crucial for cognitive assessments. Research evidence on differences in cognitive test performance in interpreter-mediated assessments is scarce, but one study indicated that scores on verbal tests (WAIS-III Vocabulary and Similarities) increased when interpreters were used, compared to when service users were assessed in their native language[74].

Extreme caution is also needed when considering using psychometric tests with d/Deaf service users[75]. Few psychometric tests or standardised assessments have been validated on the d/Deaf population, although this is changing[76].

Psychologists should:

- Make direct reference to the issue of neuropsychological and cognitive assessment difficulties when working with non-host language speaking service users and using interpreters.

- Advise appropriate level of caution when using psychometric tests.
- Advise on the impact on clinical conclusions and formulation based on psychometrics and highlight the requirement for a different approach to formulation that considers cultural issues.
- If cognitive tests are to be translated, the psychologist should discuss this with the interpreter in advance and the translation should be checked for parity of meaning and cognitive load with the original item.
- Avoid asking the interpreter to translate written items in psychometric tests 'in the moment'.
- Ask the interpreter not to give any additional assistance to service users during psychometric testing.
- Encourage the interpreter to feed back and challenge the clinician if they feel something has been misunderstood by the service user.
- Encourage the interpreter to reflect on their personal knowledge of the cultural background the service user is from and get interpreter to impart as much information as they can on e.g. education systems in original country.
- Encourage the interpreter to inform the psychologists if a word or phrase does not translate and/or if they don't know the translation.
- Consider using the interpreter when providing feedback to service users and translating a summary of their test performance for them with guidance and recommendations.

8. Psychological research using interpreters

Although a number of research studies have been undertaken exploring the use of interpreting in a variety of settings, Searight & Armock[34] note that there are few rigorous quantitative studies in this field.

When undertaking research, attention must be given to the partnership formed between the researcher and their counterpart interpreter. As noted by Harris et al.[77] this relationship can develop in such a way that the interpreter's insights and expertise lead them to a role more like that of a co-researcher. Exploring the development of this relationship reflexively, and with openness and curiosity can inform the research process. As the authors note: '*the interpreters helped the researchers, strangers in a new country and culture, feel comfortable in exploring uncharted terrain, forgave the researchers when they used Westernised lenses to examine a situation and educated them as they encountered new situations in the field.*'

Conclusion

This guidance has argued that psychologists have a responsibility to ensure that they are skilled at working with interpreters but that also the skills gained will improve practice in all areas. It has also suggested that psychologists are often uniquely well placed to help others in the settings in which they work to develop skills at working with interpreters and consider language related issues and issues related to inclusion of d/Deaf service users. This can be furthered by developing a specific *language support policy*, which considers both interpreting, inclusion and the development of translated or braille materials and resources.

Overall, it has also been shown to be advantageous when interpreters are viewed as part of the teams with which they work, shown appropriate collegial respect and supported through their work. The benefits of gaining the perspective of an interpreter or link worker can be many, and this also contributes to the duty of care that all practitioners have to their interpreters. We believe that these steps create a win-win situation in which all parties feel valued and respected, and can work for best possible outcomes across all settings.

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