

Out of the Black Box: Investigating the Experiential Impact of Psychotherapy with Refugees on Interpreters

Martina Di Braccio

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ABSTRACT

Language interpreters are pivotal in ensuring equal access to psychological therapy for refugees and asylum seekers in the United Kingdom. However, historical conceptualisations of interpreters as 'invisible' in therapy appear to have contributed to a lack of research in this setting. The current study sets out to explore interpreters' experiences of therapy with refugees and the professional support they need in this setting. Eleven interpreters participated in semi-structured interviews, which were then analysed using Thematic Analysis.

Three overarching themes were identified: What is my Role?; Emotionally Connected vs Detached; and Current Context vs Aspiration. Results highlight participants' experiences of an ambiguous and complex role and of a unique setting that poses technical and emotional challenges; interpreters' conceptualisation of their preferred support; the experienced precarity of an unregulated and poorly recognised profession; and the personal growth being an interpreter brings about.

This study has clinical and policy implications, such as organisations' obligations to offer specialised, multi-modal support to interpreters and the urgency of granting interpreting protection of title.

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1. INTRODUCTION

1.1. Overview

This thesis addresses the experiences and support needs of interpreters working in therapy¹ with refugees. This chapter will detail the research strategy, before exploring the broad context of interpreting in this setting and its specific challenges. This will be followed by a more focused review of the core studies identified as relevant. Finally, the rationale for the study and its relevance to Clinical Psychology (CP²) will be discussed, concluding with the research questions that this study aims to answer.

1.2. Literature Review Search Strategy

Preliminary literature searches were performed in November 2018. These indicated a gap in the literature regarding interpreters' experiences of therapy and of support in this setting which informed the rationale for this research. Because of the dearth of research specific to the therapy setting, from July 2019 until March 2020, a more comprehensive literature search was undertaken, aimed at identifying existing research on their experience of therapeutic³ settings more broadly and on their professional support. EBSCO databases (Psychinfo and Academic Search Complete) were used, no limit of date or geographical location was applied, but only literature in English was

¹ Throughout this paper the terms 'psychological therapy' and 'therapy' will be used interchangeably in referring to any therapeutic encounter involving a client experiencing psychological distress, their interpreter and a psychologist, psychotherapist or counsellor practicing within any theoretical orientation.

² Please consult Appendix A for a list of abbreviations used in this thesis.

³ The term 'therapeutic' is used here to refer to those settings where the interpreter has, or it is likely to have been involved in mental health or therapy work (e.g. community or public interpreting) or other health settings where they would be likely to work with trauma-related material.

included. The search resulted in 653 papers in total. After reviewing titles and abstracts, 25 core papers were identified as relevant. The excluded papers were either deemed not pertinent or too narrow in focus (e.g. service evaluations). Sign language interpreting research was also excluded. While the professions have shared challenges, sign language interpretation requires a different skillset (Darroch & Dempsey, 2016) and deaf clients have distinct needs and encounter different obstacles compared to the refugee population (Levine, 2014).

More literature was identified from the selected papers' reference lists and in conversation with academic staff and experts in the subject. Relevant policies and guidelines were accessed through governmental bodies' websites. A more detailed flow diagram, inclusive of the search terms used, can be found in Appendix B.

1.3. Reflexive Considerations when Approaching the Literature

1.3.1. Who Holds the Power in Therapy with Interpreters?

Before delving into the literature, it is important to acknowledge that the parties of the three-way therapeutic interaction are not equally represented in academic discussions. The research available has been overwhelmingly completed by mental health professionals, which means most of the subject matter is grounded in a particular subset of theoretical and epistemological assumptions. This predominance is not surprising, since the occupational structure of interpreting work (mostly freelance) and the lack of representation in academia, would not facilitate the production of research.

Such research inequality mirrors the power disadvantage interpreters experience in therapy, the result of several factors: interpreters often come from minority backgrounds themselves and speak English as a second language, which inherently grants them reduced power in a predominantly White British healthcare setting; their occupation is less protected, recognised and lower paid compared to their therapist colleagues and they often depend on the latter for their work; and undertaking non-contracted employment and lacking training and/or briefing often means that interpreters may enter interactions with little

preparation regarding rules and expectations, leading to a reduced sense of control (Becher & Wieling, 2015; Molle, 2012).

Therapists' attitudes have also played a role in this inequality by historically considering interpreters as 'add-ons' and 'processing machines' rather than active agents in therapy. It has been argued that such mechanistic narratives reinforce a hierarchical top-down approach in the provider⁴-interpreter relationship (Hsieh & Kramer, 2012) and may also be a contributing factor as to why research, until recently, has neglected interpreters' internal world in therapy. This will be further explored later in this chapter.

Some authors have argued that such marginalisation may be rooted in interpreters' representing a perceived threat for clinicians. Therapists are largely used to working "behind closed doors", dominating the therapy space and may feel anxious about being "good enough" in front of other professionals (Hsieh & Kramer, 2012, p.162). Interpreters' may also raise discomfort for therapists' who perceive a lack of control over communication and may feel excluded from interpreter-client conversations and rapport (Tribe & Thompson, 2009a), with some therapists entering a "hidden tug-of-war ... competing for the patient's affection and trust" (Hsieh & Kramer, 2012, p.162).

1.3.2. Self-Reflection and Relationship to the Subject

My review of the literature itself is not free from the above dynamics, given that I am myself a white, Italian, UK-educated mental health professional. Therefore, I reflected on what led me to be interested in interpreters' experience of therapy and how this may influence my assumptions throughout this paper.

My interest comes from my own work with the refugee population. As a support worker in a refugee charity, I was occasionally asked to interpret for Spanish and Italian-speaking clients, without the training to do so. This triggered significant anxiety for me, fearing that my interpreting mistakes would impact on

⁴ The term 'provider' is used in the interpreting literature to indicate the professional making direct use of the interpreter's services (e.g. the therapist or solicitor). This is often different with the intermediary hiring company, which is referred throughout this paper as an 'agency'.

clients' care. Being a foreigner myself and knowing only too well how unsettling it feels to lack language skills in daily interactions exacerbated such concerns.

As an assistant psychologist, I was supported by interpreters when working with victims of torture, working regularly with one particular interpreter. This relationship was highly collaborative, and I found comfort in the support of my colleague during emotive sessions. The work was emotionally demanding for me and I often wondered about its effects on my interpreting colleagues.

These experiences influence my position on therapy with interpreters, especially the importance I give to working with trained interpreters and including them in a triadic relationship (Tribe & Thompson, 2009a). In my experience, I observed a busy, under-funded therapy world struggling to include and support interpreters. This led to a firm belief that interpreters' well-being at work needed attention from clinicians like me. An extensive exploration of the literature helped me ensure I was not only driven by such experiences but that I was addressing a reasonable and much needed gap in the literature, which we will explore in the remainder of this chapter.

1.4. Literature Review: Setting the Context

Before moving on to a more focused literature review, the following section will provide an introduction as to why interpreters are needed, the historical and current role they play in therapy and some of the specific challenges they encounter.

1.4.1. Current Migration Context and Definitions

In recent years, the world has seen a steep increase in migration to Western countries, with many fleeing poverty, persecution and war. According to the United Nations High Commissioner for Refugees (UNHCR) there are currently 70.8 million forcibly displaced people worldwide. In 2018, the UK was home to 126,720 refugees and received 32,693 new asylum applications, 21% more than 2017 (UNHCR, n.d.a, n.d.b).

The 1951 United Nations (UN) Refugee Convention defined a *refugee* as "someone who has been forced to flee" their country "because of a well-

founded fear of persecution for reasons of race, religion, nationality, political opinion or membership in a particular social group” (UNCHR, 2010, p.3). An *asylum seeker* is a person who is seeking sanctuary in another country, but whose asylum claim has not yet been decided and they are yet to be granted refugee status. In some countries, including the UK, a minority of asylum applications are accepted (Amnesty International, 2019). Because the literature in the field uses both terms interchangeably, and both groups are entitled to public healthcare and often require interpreters to access psychological therapy (Public Health England, 2014), the term ‘Refugees and Asylum Seekers’ (RAS) will be used in this paper in referring to this heterogeneous population.

1.4.2. The Need for Language Interpreters

Many RAS have experienced traumatic events before, during or after their migration (Tribe & Patel, 2007). As a consequence of these hardships, RAS tend to present with higher levels of psychological distress compared to the general population (Fazel, Wheeler, & Danesh, 2005). This group is also exposed to other challenges such as urgent welfare needs, poorly treated physical health complaints, isolation and acculturation (Peel & Burnett, 2001; Porter & Haslam, 2005).

In order to support large numbers of RAS, many of whom do not speak English, public and charitable organizations in Britain are coming under increasing pressure. Language interpreters are now more important than ever in facilitating these services and the number of organizations looking for interpreters is rising (National Register of Public Service Interpreting [NRPSI], 2019a).

Psychological therapy is the recommended treatment for people experiencing mental distress and traumatic reactions, relying almost exclusively on verbal communication (National Institute for health and Care Excellence [NICE], 2018). Psychological professions in Britain have become increasingly aware of being problematically White and that clinicians do not represent the population they serve, neither culturally nor linguistically (Patel & Keval, 2018). It has also become evident that services are comparatively less accessible to people from Black Asian and Minority Ethnic (BAME) communities, with language and cultural understandings being considerable barriers (Memon et al., 2016).

While family members have acted as interpreters in the past, this is now largely discouraged (except in specific circumstances) due to accuracy (Karliner, Jacobs, Chen, & Mutha, 2007; MacFarlane et al., 2009) and being burdensome for the person interpreting, often young people (Cline, Crafter, & Prokopiou, 2014). Therefore, psychologists are urged to work effectively with professional interpreters to foster effective communication and create inclusive services (British Psychological Society [BPS], 2017) as part of a public health responsibility to tackle health inequalities (Equality Act, 2010; Human Rights Act, 1998; Macpherson Report, 1999).

Despite historical narratives that using interpreters is burdensome on services, evidence shows their involvement leads to better quality care (Karliner et al., 2007) and is an economical allocation of resources in the long term (Bischoff & Denhaerynck, 2010).

1.4.3. Employment and Training

Despite such clinical and financial benefits, and widespread employment of interpreters in a variety of public settings (e.g. hospitals and courts), the profession remains poorly regulated. While NRPSI facilitates the registration of interpreters holding a Diploma in Public Service Interpreting (DPSI), organisations are not bound to hire registered professionals due to the lack of protection of title for interpreting in Britain. The register's latest report showed only 1730 registered qualified interpreters, and this had almost halved compared to 2012. This decline is largely attributed to qualified interpreters leaving the public sector because of poor pay conditions, and an increase of untrained interpreters being employed through private agencies (NRPSI, 2019a).

Professional registration not only regulates interpreters' training, but it ensures they adhere to NRPSI's code of conduct, encompassing a set of professional and ethical rules, including the principles of the interpreters' *neutrality* in interactions and their respect of customers' *confidentiality*, which are historic pillars of the profession. NRPSI's position is that public attempts to save money in this sector are having a "domino effect", and greatly impacting on the quality and integrity of health and legal services (NRPS, 2019a, p.5).

There is no official mental health qualification for interpreters, with those working in this field having a DPSI law or health qualification, or more commonly no qualification at all. It is recognised that many issues arising in interpreter-mediated therapy could be avoided with better quality training for interpreters and for the clinicians working alongside them (Tribe & Sanders, 2003).

1.4.4. Modes of interpreting

Being employed by agencies, most interpreters work across providers and settings (e.g. legal, medical, and psychological) with different rules and expectations. This leads them to vary their approach depending on personal preference and service needs. In the latest BPS guidelines on working with interpreters, Tribe & Thompson (2017) acknowledge such heterogeneity and attempt to summarize the different stances interpreters can take in four main *modes*, outlined below.

In *linguistic mode* (also called *conduit* or *black box*), the interpreter focuses on interpreting word-for-word, taking a position of distancing and neutrality.

Conversely, an interpreter adopting *psychotherapeutic mode*, is less concerned about literal translation and aims to convey the meaning and feeling of what is being communicated. In *advocate/community mode*, the interpreter takes on additional tasks, advocating for the client more broadly. Lastly, in *cultural broker/bicultural worker mode*, the interpreter is also expected to provide input around culture and context.

The debate around which role is to favour in therapy, will be discussed next.

1.4.5. Towards Interpreters as 'Visible' Beings in Therapy

The use of interpreters in therapy is an area of longstanding debate. With the historic predominance of psychoanalytic approaches, focused on a neutral setting between therapist and patient where the unconscious can play out undisturbed (Leiper, 2014), it is unsurprising that having a third person in the room initially raised concerns. Still today, therapists are apprehensive of interpreters' presence interfering with transference, projection, intimacy and therapeutic alliance (Bhui & Morgan, 2007; Haenal, 1997). To minimize the risk of therapeutic disruption, 'black box' or conduit models have historically been

used, where the interpreter is conceptualized as a translating machine and should aim to be 'invisible' in sessions (Westermeyer, 1990).

With increasing questions around the intercultural applicability of Western psychological models (Patel & Keval, 2018) and growing evidence showing that interpreter-mediated psychological therapies are effective (Psychodynamic: Brune, Eiroá-Orosa, Fischer-Ortman, & Haasen, 2014; Cognitive Behavioural Therapy [CBT]: D'Ardenne, Ruaro, Cestari, Fakhoury, & Priebe, 2007), some cross-cultural psychology experts are calling for a paradigm shift, moving from viewing interpreters as intrusions towards valuing them as resources, cultural informants and active members of the therapeutic relationship (Tribe & Thompson, 2009a).

Researchers from the interpreting community have also challenged the conduit model, advocating for better conceptualizations encompassing the many complex competencies (e.g. technical, emotional and interpersonal) interpreters are required to juggle (Arocha, 2005; Bontempo & Malcolm, 2012). A growing body of research indicates that interpreters' views vary on their perceived role in therapy (Miller et al., 2005), but that a majority identify a greater role than only language processors, (Dubus, 2015; Mirdal, Ryding, & Essendrop Sondej, 2012). In the following sections, I will discuss the contribution of interpreters to cultural understanding, therapeutic engagement and building trust in therapy with RAS.

1.4.5.1. The interpreter's cultural contribution

In recent years, particular emphasis has been put on the cultural advisory role of interpreters (Katan, 2004; Tribe & Thompson, 2009b). Valero-Garcés (2005, p.90) defines interpreters as "catalysts", cultural brokers bridging meanings of "community life, the distribution of functions and responsibilities in the family, and stories of misfortune, honour, religion, and faith". It has been argued that interpreters' linguistic and cultural functions are often inseparable, since languages are multidimensional and carry cultural meaning (Tribe, 2007). This is particularly true in therapy, where psychological understandings are culturally bound (Tribe & Morrissey, 2002) and most psychological theory and terminology has been constructed in Western society and does not have a direct translation universally.

1.4.5.2. The interpreter's contribution to the therapeutic relationship

Alongside their cultural role, literature is growing on the relational roles the interpreter has in therapy, indicating that they represent one active member of a complex and therapeutic relationship in a “triad” (Tribe, 1998, p.210; Millet et al., 2005). Such findings are of great interest in therapy, considering therapeutic alliance is the core factor in predicting effectiveness, regardless of the therapeutic orientation offered (Ardito & Rabellino, 2011).

A Danish qualitative study by Mirdal et al. (2012, p.442) with refugee clients, their therapists and their interpreters found that a good three-way therapeutic alliance based on “trust” and “solidarity” was considered a core “curative factor” by all parties. Similarly, in an American study by Miller et al. (2005) with interpreters and therapists working with RAS, not only did participants highlight the importance of a trusting relationship between the interpreter and the client, but clinicians also valued interpreters’ support when faced with distressing material in sessions.

Research is scant on how service users perceive relationships with interpreters in therapy. However, in a pilot study in the UK, while clients acknowledged the challenges posed by having therapy through interpretation (e.g. talking in chunks or being interrupted) they nonetheless reported valuing a “collaborative triangularity” and interdependence between all parties (Costa & Briggs, 2014, p. 240).

However, as highlighted by Miller et al. (2005), it is undeniable that developing a three-way alliance differs from direct dyadic therapy, with their participants describing the process as more gradual. For example, it is not uncommon for clients to initially create a more intense emotional bond with their interpreters due to feeling that they understand them linguistically and they share similar background and experiences (Valero-Garcés, 2005).

1.4.5.3. The interpreters' contribution to engagement

This stronger initial bond places interpreters in a particularly good position to support clients’ engagement in therapy. Trust is understandably hard to build in this population, since RAS have often been failed repeatedly by people who promised support and shelter, and/or been abused by the state (Turner, 1990). Further, while White Western ‘helpers’ (clinicians or interpreters) may be

perceived as threatening by some clients due to echoing colonisation trauma or more recent experiences of abuse during their journeys (e.g. detention centres, modern slavery), interpreters have been found to foster a safe space and to help combat mental health stigma among communities that are unfamiliar and suspicious of therapy (Miller et al., 2005; Tribe & Thompson, 2009b).

The importance of working with a trusted interpreter is reflected in the now consolidated guidance to have the same person consistently interpreting for the entire course of therapy (BPS, 2017) and it is not uncommon for clinicians to cancel a therapy session if the usual interpreter is unavailable. Gartley & Due (2017) describe episodes when changing interpreter mid-way through therapy created such discomfort that the client disengaged.

However, gaining clients' trust is not without obstacles for interpreters. Anecdotal and research reports indicate that it is not uncommon for clients to mistrust interpreters for fear of their political alignment, or of them being from the 'enemy' group (e.g. in ethnic wars) (Tribe, 1999). Furthermore, political refugees and victims of torture may have well-founded fears of persecution by their home governments while living in Europe, and of putting their families back home at risk (Patel, 2003). In small communities, interpreters can also face mistrust around confidentiality (Gartley & Due, 2017).

1.4.5.4. Maintaining neutrality

Authors have discussed how such complex and relational roles in therapy may conflict with the principle of *neutrality* (or *impartiality*). Interpreting codes of conduct state that the interpreter "shall at all times act impartially" (NRPSI, 2016, para. 3.12), and that they must show "integrity" by "not allowing themselves to be improperly influenced either by self-interest or the interests of others" (Institute of Translation and Interpreting, 2016, p.6).

However, interpreting experts have argued that one's own emotions and biases lead to significant dilemmas on this matter (Muriel, 2020). Research with interpreters has also highlighted these concerns (Shakespeare, 2012). For example, a US-based qualitative study by Dubus (2015) reported healthcare interpreters felt drawn towards protecting clients' emotional experience, and balanced themselves in relation to the provider's attitude, becoming more

empathic if they perceived distance in their colleague, and less involved if the professionals were emotionally present.

Bontempo and Malcolm (2012, p.110) go so far as to label neutrality in healthcare as a “myth” and consider it an unwanted consequence of the mechanistic models, which deny interpreters’ human reactions and expect them to “block” their “self”. Conversely, interpreting consultant Baker-Shenk (1986) has argued that hiding behind the pretence of ‘neutrality’ has been a strategy of the interpreting profession to withhold responsibility in interactions, instead of taking a political stance alongside the oppressed groups they serve (Freire, 1970).

1.4.6. Summary

Psychologists have the responsibility to work effectively with language interpreters, who are pivotal in facilitating access to health services to an increasing number of RAS in Britain. While there has been a tendency within psychological therapy to consider interpreters as ‘not to be seen’ language processors, increasing evidence supports them playing a greater role in the therapeutic relationship, such as ‘bridging’ meaning between clinicians and communities. A more relational paradigm might challenge previous conceptualisations of interpreters as ‘neutral’ and ‘machine-like’ which may have contributed to the neglect of research on interpreters’ experiences of therapy and the support they need in these spaces, as will be discussed in the next section.

1.5. Literature Review: Interpreters' Experiences of Therapeutic Settings and Professional Support

Due to the constrained literature specific to interpreting in therapy with RAS, this review includes papers identified as relevant to the experiences of interpreters in therapeutic⁵ settings more broadly. In total, 25 papers were identified: 7 quantitative, 17 qualitative and 1 mixed methods.

The literature findings are presented in four overarching themes: 'the emotional experience of interpreters', 'challenges of the professional setting', 'coping' and 'support and training'.

1.5.1. The Emotional Experience of Interpreters

The majority of the papers identified in the literature search focused on the emotional experience of interpreters. Where quantitative studies have approached the matter using standardised measures of psychological 'impact' or surveys, qualitative studies engage in a more open exploration of interpreters' personal accounts. Both quantitative and qualitative literature suggests interpreters experience a mix of psychological distress as well as satisfaction and growth as a consequence of their work.

When referring to the adverse psychological consequences of interpreting a variety of constructs have been used in the literature. For example, the concept of 'Vicarious Trauma' (VT) has been extensively employed (Deville, Wright, & Varker, 2009; Kadambi & Truscott, 2004; McCann & Pearlman, 1990). Originally referring to "the transformation in the inner experience of therapists . . . as a result of empathetic engagement with clients' trauma" (McCann & Pearlman, 1990, p.145), it has been extended to other professionals working with trauma survivors. In refugee work, VT has been found in therapists (Barrington & Shakespeare-Finch, 2013), healthcare staff (Puvimanasinghe, Denson,

⁵ The term 'therapeutic' is used here to refer to those settings where the interpreter has, or it is likely to have been involved in mental health or therapy work (e.g. community or public interpreting) or other health settings where they would be likely to work with trauma-related material.

Augoustinos, & Somasundaram, 2015) support workers (Guhan & Liebling-Kalifani, 2011) and helping professions in general (Cieslak et al., 2014). 'Secondary Traumatization' (ST) is often used interchangeably with VT, but it is conceptualised specifically as helpers' (e.g. therapists, family members) cognitive and emotional changes that mirror trauma-related distress of the person they help. This construct refers specifically to changes associated with the Post-Traumatic Stress Disorder (PTSD) diagnostic label (e.g. cognitive intrusions and avoidance) (Jenkins & Baird, 2002).

Furthermore, Compassion Fatigue (CF) was introduced after noticing a combination of ST and occupational burnout traits in helping professionals ("caregiver burnout"; Figley, 2002, p. 1433). Occupational burnout is a more common and broader concept used across professional settings in referring to "chronic workplace stress" involving exhaustion and a negative view of self and the world (World Health Organisation, 2018).

On the positive side of the emotional effects, 'Vicarious Post-Traumatic Growth' (VPTG; Arnold, Calhoun, Tedeschi & Cann, 2005) may occur for professionals working alongside trauma survivors who experience "positive change" as a result of supporting others through "highly challenging life crises" (Tedeschi & Calhoun, 2004, p.1). More generally, the term 'Compassion Satisfaction' (CS) is used when referring to the emotional "rewards of caring for others" (Cetrano et al, 2017, p.1).

1.5.1.1. Quantitative Findings

Four papers were found that approached the emotional impact of interpreting using standardized measures of psychological constructs. Three of these found interpreters to be psychologically impacted by their work, one did not find this group to be more affected than the general population.

Kindermann et al. (2017) assessed the prevalence of traumatisation, ST, depression, anxiety and stress in interpreters working in medical and psychosocial care with RAS in Germany (n=64). The following measures were used: Essen Trauma Inventory, Questionnaire for ST, Patient Health Questionnaire, Generalised Anxiety Disorder Scale, Perceived Stress Scale, Sense of Coherence Scale, Social Support Questionnaire and Relationship Questionnaire. It was found that 9% of the sample met criteria for PTSD and ST

was found in 21% of the sample as well as higher rates of anxiety, depression and perceived stress compared to the general population. Similarly, a US-based study by Mehus & Becher (2016) assessed ST, CS and burnout among healthcare interpreters (n=119) using the Professional Quality of Life scale. This study also showed higher rates of ST relative to population norms and increased CS but found no significant difference in burnout.

The relationship between CF and CS, burnout and coping among clinicians (n=27) and interpreters (n=19) working with trauma survivors was investigated in a mixed method unpublished study by Salihovic (2008). The quantitative element of this study adopted the following measures: CS/CF Self-Test for Helpers and Hogan Empathy Scale. Participants were found to be at 'moderate' risk of CF and at 'high' risk of burnout.

However, the above results contrast with a US-based unpublished study by Shlesinger (2006) aimed at assessing VT and burnout among interpreters (n=53) working in treatment centres for survivors of torture. Interpreters' scores on the Trauma and Attachment Belief Scale and Compassion and Satisfaction Belief Scale did not suggest higher rates of VT or burnout compared to the general population and hypothesised exacerbating factors (trauma history, lack of supervision and lack of therapy) were not found to have an impact.

Four quantitative studies with a survey design were also found, all of which suggest interpreters experience psychological distress as a consequence of their work. For example, Loutan, Farinelli, & Pampallona (1999, p.280) presented survey results on the impact of interpreting on a sample of 18 interpreters working with RAS in the Swiss Red Cross: 28% reported "frequent difficult feelings during the session", 66% "frequent painful memories" and 83% felt the need to talk with a medical doctor after the sessions.

Similarly, in her review of the psychological impact of public service interpreting, Valero-Garcés⁶ (2005) mentions a large survey with public service interpreters

⁶ Several attempts were made to access primary sources, including contacting the authors. Since these were unsuccessful, secondary sources were used for this paper.

(n=295) in several European countries by Baistow (2000, as cited in Valero-Garcés, 2005, para. 31; and in Lai, Heydon, and Mulayim, 2015). 49% of respondents reported becoming upset or worried because of their work and 50% of these reported the effects as lasting longer than a day. These were attributed to the “distress of clients” (67%), “hearing about suffering and misery” (58%), and “being unable to directly help clients” (39%).

This is supported by a Scottish survey (n=18) of mental health interpreters by Doherty, Macintyre, and Wyne (2010, p.34) which found that 56% of interpreters working in mental health were emotionally impacted by their work and 67% struggled to keep clients out of their mind. Furthermore, in a large survey (n=271) completed by Lai et al. (2015) with public service interpreters in Australia, not only did 78% of responders state that traumatic content affected them for some time following an assignment, but half of them reported that they would avoid similar jobs in the future. 21% thought that their emotional responses impacted on the quality of their interpretation.

1.5.1.1.1. Mediating Factors

Some of the studies above looked at the relationship between psychological well-being among interpreters and potential factors that might compound or lessen the impact of the work. Perhaps unsurprisingly, results indicate a correlation between the amount of time spent working with trauma survivors and increased psychological impact (Loutan, Farinelli, & Pampallona, 1999; Salihovic, 2008; Shlesinger, 2006). Similarly, Shlesinger (2006) found levels of burnout to correlate with professional experience in the field.

Some studies mention empathy as possibly playing a role in VT and work-related distress. Whether this role is protective (Mehus & Becher, 2016; Splevins, Cohen, Joseph, Murray, & Bowley, 2010) or exacerbating (Harvey, 2003; Herman, 1992) is still a matter of debate. While all-sample results (involving clinicians and interpreters jointly) in the study by Salihovic (2008) showed an association between higher empathic ability with greater CF, analysis focusing only on the sample of interpreters showed that low social support was a stronger predictor of CF.

Social support was also found to be a protective factor in the study by Kindermann et al.'s (2017), alongside sense of coherence, and attachment

style. Furthermore, Mehus & Becher (2016) hypothesised that the low burnout in their sample might relate to the increased CS identified, which might act as a buffer, since a similar dynamic was found among therapists working with sexual violence survivors (Samios, Abel, & Rodzik, 2013).

Moreover, some of the studies mentioned attempt to answer the question as to whether prior experience of trauma and a forced migration background put interpreters at increased risk of being affected by their work. Quantitative results on the matter are mixed. Mehus & Becher (2016) found that refugee interpreters did not present with higher levels of ST and hypothesised this group might experience higher levels of empathy which may have a protective function. On the other hand, while Shlesinger (2005) did not find higher levels of VT among interpreters who experienced trauma themselves, levels of burnout were significantly higher. In Salihovic's (2008) study exposure to traumatic events was one of the strongest predictor of CF.

1.5.1.2. Qualitative Accounts

In line with quantitative results, in-depth qualitative studies highlight the psychological distress working as an interpreter can bring about. However, qualitative accounts also offer a greater recognition of the positive ways interpreting contributes to people's emotional lives.

A US-based exploratory study by Miller et al. (2005) investigated the experiences of fifteen interpreters (thirteen of whom were refugees) and fifteen clinicians working in therapy with RAS. Participants reported experiencing intense emotions during and after sessions due to hearing trauma stories, although this distress was short lived and decreased with experience. Even though this was uncommon and not always problematic, all therapists recalled interpreters becoming noticeably emotionally affected by clients' stories.

Similarly, Roberts (2015) reports experiences of distress among their participants (ten community interpreters in Wales). However, they described becoming distressed after, rather than during, the session and they attribute this to technical demands taking priority during the interpretation. In the long term, participants described becoming more cynical of others' intentions. These results are in line with a doctorate thesis by Gomez (2012, p.30) on interpreters

working in therapy with RAS in Ireland (n=6) whereby a core theme identified was “the need to handle difficult emotions and their impact”.

Gallagher, Melliush and Löfgren’s (2017, p.338) report similar experiences of distress in six Polish community interpreters working in mental health in Britain. In this study, most participants linked work-related distress to feeling unprepared to hear the material disclosed as well as feeling resonance in their personal life. A similar theme of identification is highlighted by Shakespeare’s (2012, p.115) in a study with eight community interpreters in Britain, whereby a core theme identified was “feeling for the client”. Participants describe a real desire for empathic engagement with the client, leading to “becoming overwhelmed with distress due to a process of identification”. Remaining neutral in the therapeutic relationship was a perceived challenge and processing traumatic material was described as leading to emotional distress lasting hours or days.

In a study on interpreters working in forensic settings in the UK, Molle (2012, p.51) additionally highlights the tendency of interpreters to “internalise negative emotions felt by clients” and provides some novel information on the “disorientation” forensic units can trigger for interpreters entering this setting.

Two studies focused specifically on the experience of interpreting sexual violence stories (Butler, 2008; Dhinse, 2017, p.60) which was described as an intense and difficult emotional experience. Common themes were “feeling the trauma” and “becoming the client” during the session. Interpreters also reported viewing the world as less safe as a consequence of their work and talked about their struggles to maintain the ‘invisible’ stance expected of them.

Furthermore, some research has focused specifically on the emotional experience of interpreters with a refugee background and how they juggle their personal and professional identities. In this specific group, identification appears to be particularly relevant. For example, Green, Sperlinger & Carswell (2012, p.231) explored the experiences of six Kurdish refugee interpreters working in UK mental health services. Participants describe often feeling overwhelmed with “unmanageable emotions” and that stories felt often “too close to home” and “too heavy to handle” (Green, Sperlinger & Carswell, 2012, p.230).

Participants also discussed “clashing cultures” and the friction between their Kurdish and British selves.

Holmgren, Søndergaard, and Elklit (2003, p.25) interviewed twelve Kosovo-Albanian interpreters at the Danish Red Cross. Participants reported high levels of distress and problems “letting go” of work. Distress was attributed both to the powerlessness and guilt they felt for not being able to support their country from afar as well as the content of their work as interpreters. They considered the work with psychologists to be the hardest, due to the detailed trauma descriptions.

Alongside difficult feelings, most of the studies also highlight themes relating to “inspiration, learning and satisfaction” (Gomez, 2012, p.30; Roberts, 2015; Salihovic, 2008). For example, in the study by Roberts (2015, p.35) participants reported perceived growth, increased self-confidence and a tendency to “put things into perspective”. In the study by Miller et al. (2005) participants revealed that their work had improved their lives, helped them make sense of their own histories and overall made them more compassionate. In their meta-synthesis of many of the studies mentioned, Yick and Daines (2017, p.15) noted a theme of “existential growth” brought by witnessing the clients’ journey and “metaphorically holding another’s hand through healing”.

Splevins, Cohen, Joseph, Murray, and Bowley (2010, p.5) focused specifically on VPTG among eight interpreters working in therapy with trauma survivors in the UK. While all participants mentioned experiencing some level of work-related distress such as “feeling with the client” when interpreting content “beyond belief”, results highlighted how interpreters experience a similar journey of growth alongside their clients. Some even described this as “free therapy”. Participants recount feeling more connected and compassionate and less attached to material goods.

A study by Johnson, H., Thompson, A., & Downs, M. (2009) also brings attention to the protective role played by interpreting in the lives of nine refugee interpreters’ in the UK. Participants found their work helped them cope with their own histories, stay connected to their culture and maintain a sense of shared community trauma.

1.5.2. Challenges of the Professional Setting

Alongside the emotional complexity of the job, the literature suggests interpreters face many occupational challenges in relation to the technical and financial aspects of the job as well as the professional relationships involved.

1.5.2.1. Quantitative Findings

In the survey by Baistow (2000, as cited in Valero-Garcés, 2005, para. 31; and in Lai, Heydon, and Mulayim, 2015) interpreters cited a series of employment struggles contributing to difficult feelings and worry, such as “concerns about future employment” (35%), “dealing with service providers” (30%) and “unpredictable working hours” (28%). Interestingly these results varied across countries. For example, German-based interpreters were more concerned about working conditions, while UK-based interpreters reported more isolation and loneliness. This is supported by findings in Doherty, Macintyre, and Wyne (2010, p.34) where 28% of participating interpreters reported avoiding mental health work due to being more “intensive” and inadequately paid. 28% found interpreting for RAS especially difficult, with “establishing rapport” with the client being the most selected challenge.

1.5.2.2. Qualitative Accounts

Even though the focus of most of the qualitative papers is the emotional experience of interpreters, some refer to the perceived professional challenges of the interpreting setting. For example, this theme was present in the meta-synthesis by Yick and Daines (2017, p.15) on interpreters working across health and mental health (all but one⁷ of the papers analysed are included in this review). Alongside distressing feelings and identification, the paper refers to more practical “internal stressors” such as: needing to manage “multitasking” and “technicalities” of interpreting (especially the tension between translating words and meaning). Furthermore, “workplace stress” was a core “external stressor”, including the instability of the workload, poor wages, and

⁷ One paper was not deemed relevant due to focusing exclusively on interpreters working in an oncology setting.

inappropriate support, as also highlighted by Gallagher, Melliush and Löfgren's (2017).

Many of the studies mentioned also refer to issues in professional relationships, such as perceived mistrust from clients and therapists and not feeling appreciated at work (Dubus, 2015; Gomez, 2012). For example, McDowell, Messias and Estrada (2011) interviewed 27 interpreters working in healthcare in the US. The work was described as "complex, challenging, exhausting, and often invisible" by participants, highlighting a lack of recognition of the emotional and technical skills required to interpret in healthcare (McDowell, Messias, & Estrada, 2011, p.137). Participants were seen as having to juggle different expectations between clients and providers. Some also note that providers' behaviour greatly influenced interpreters' job satisfaction (Dubus, 2015). In Shakespeare's study (2012, p.115), interpreters shared feelings of "powerlessness" and feeling unable to question practitioners' decisions. Also Molle (2012, p.51) reports their participants (interpreters in UK forensic settings, n=6) felt "demeaned" by other professionals who saw them as "mere machines" and not allowed opinions or feelings.

Furthermore, a US-based study by Dubus (2015) provides further information on the perceived professional challenges of working with RAS specifically, by interviewing 36 interpreters' working with this group in healthcare. Participants mention the increased cultural brokerage and the high needs of RAS going beyond what clinicians can provide, which led participants to feel pulled to do more than linguistic services.

1.5.3. Coping

Most of the studies mentioned above provide some information on how interpreters cope with the challenges of the work.

1.5.3.1. Quantitative Findings

In the Scottish survey by Doherty, Macintyre, and Wyne (2010, p.34) common coping strategies adopted by interpreters were "thinking through", reminding themselves "how important the work is" and talking to the therapist after the session. In the survey by Baistow (2000, as cited in Valero-Garcés, 2005, para. 31) participants report three main methods of coping with the impact of the

work: “talking about work problems”, “increasing social relationships” and “practising sport and exercise”.

1.5.3.2. Qualitative Accounts

In line with this limited survey data, qualitative accounts factor a combination of internal and external support strategies which helps interpreters in maintaining an “equilibrium” or creating a “shield” to avoid being “sucked in” by emotions (Splevins et al., 2010, p.7). Among external strategies, most studies reported the importance of good social support outside of work (Dhinse, 2017; Green et al., 2012; Roberts, 2015; Splevins et al., 2010; Yick & Daines, 2017). Personal strategies and activities were also highlighted such as exercising, cooking, and religious practice (Dhinse, 2017; Gomez, 2012; Roberts, 2015; Salihovic, 2008; Splevins et al., 2010). Interpreters in Splevins et al. (2010) additionally reported finding counselling helpful. In a minority of studies participants described not having coping strategies in place (Green et al., 2012) or using self-medication or alcohol to cope with difficult emotions (Holmgren et al., 2003).

Regarding internal strategies, many relied on distraction (Miller et al., 2005; Molle, 2012), humour, positive self-talk and rationalising to avoid overwhelm (Gomez, 2012; Salihovic, 2008). Participants in Miller and colleagues’ (2005) study reported they had to learn to tolerate difficult feelings and remind themselves what they do is important. Researching clients’ backgrounds to understand abuse in its “political context”, as a way of “rationalising” it, was reported by Dhinse (2017, p.77).

Most studies mentioned cognitive avoidance of and detachment from clients’ emotion and traumatic experiences as common self-protective strategies (Yick & Daines, 2017; Salihovic, 2008; Shakespeare, 2012). Participants in Dhinse’s (2017) study highlighted switching to third person interpretation to aid such distancing. Some papers described an oscillation between identification with clients and seeking distance as a consequence (Butler, 2008; Dhinse, 2017; Shakespeare, 2012).

In some studies detachment strategies also appeared to be related to interpreters’ discomfort (Shakespeare, 2012; Molle, 2012) or shame (Gallagher et al., 2017) at displaying emotion at work, fearing negative judgement. Baillot, Cowan, & Munro (2013) highlighted similar worries in legal professionals

(including interpreters) working with RAS more broadly. In Gomez' (2012) study, four interpreters mentioned that being 'professionals' meant restraining their feelings during sessions. In some of these accounts, such views on escaping emotion appear to intersect with interpreters' expected neutrality (Green et al., 2012). Echoing Bontempo and Malcom (2012), who accused these expectations of neutrality of being unrealistic, Molle (2012, p. 67) defined this as a "catch 22", "whereby [interpreters] cannot block their emotions as desired and be a machine, yet they feel that they cannot disclose or display them".

1.5.4. Support and Training

Such denying of interpreters' emotional experience may have played a role in the lack of support available to interpreters, as extensively highlighted in the papers discussed (e.g. Salihovic, 2008; Gallagher et al., 2017; Miller et al., 2005) and the broader literature in the field (Tribe & Raval, 2003). Despite such awareness, specific literature on the matter is extremely scant and is limited to survey data or clinicians' accounts of support groups.

1.5.4.1. Quantitative Findings

Some information is provided by Lai et al. (2015). Their survey evidenced that, despite the significant reported levels of work-related distress among responders, 70 % of interpreters said they had not sought support, with 'no need' being the most frequently reported reason. A minority replied they did not have the time, money or did not know where to go for help. Those who did seek support, mostly relied on talking to colleagues and family.

While not including interpreters' views, a survey study was found aimed at investigating management attitudes towards employee support (including for interpreters) at 84 humanitarian aid Non-Governmental Organisations (NGOs) (many working with RAS) in 14 European countries (including the UK) (Dergam & Valero-Garcés, 2001). Most organisations did not offer psychological training and only 39% were worried about their employee's psychological well-being and wanted to improve the limited support structures they had in place. Only one third of the organisations reported being concerned about interpreters' welfare after a humanitarian mission. Lacking the resources needed to offer such services was highlighted as a core issue.

1.5.4.2. Qualitative Accounts

Two qualitative papers were found on support for interpreters, that report clinicians' experience of running support groups. Tribe (1998) reflects on her experience of facilitating a 5-year running supervision group for bicultural staff working with RAS in London. The author describes how the interpreters found it hard to engage early on and how conflict arose around the scope of the group (emotional support versus practical challenges). Eventually, this became a safe space where the most prominent themes were relational issues arising within the triad, conflict of boundaries and the struggle to cope with the emotional content of sessions. Tribe (1998) named some of the challenges encountered, such as work competition between same-language interpreters, attending workers changing frequently and external factors such as suspicion displayed by staff from other disciplines. She described the tension caused by being both a facilitator and working for the organisation hiring the interpreters, as well as needing to pay attention to the power held by facilitators (White British psychologists) compared to the participants (often refugee women). Nevertheless, the author reports organisational culture changes and an increased recognition of the role of bicultural workers as a direct consequence of the group. This was mirrored by practical changes such as the introduction of a separate waiting room for interpreters and the hiring of an interpreter coordinator. Participants were paid their regular hourly rate to attend.

Sande (1997) provides a detailed account of the dynamics involved in a series of supervision groups for refugee interpreters run over 5 years in Norway. The group appeared to take a more 'top down' approach compared to Tribe's (1998), describing the psychiatric professionals as 'leaders' and involving significant teaching to interpreters alongside some more open reflection time. The group reportedly strengthened interpreters' professional identity and self-esteem, giving a voice to professionals who often go undervalued. It also allowed for peer dialogue on how to manage the often-unrealistic expectations of clients and professionals. Other outcomes discussed included normalising difficult emotions and exploration of professional dilemmas (e.g. how to manage relationships with clients when belonging to the 'enemy' ethnic group). The importance of skilled facilitation to ensure all members have a voice and avoid or reflect upon dynamics of exclusion was highlighted.

Across the qualitative and quantitative literature discussed, interpreters report finding briefings and debriefings with therapists very valuable, but that therapists were rarely able to offer them due their tight schedule (Miller et al., 2005; Green et al., 2012). These reports are concerning, especially since Doherty, Macintyre, and Wyne's (2010, p.34) report that 78% of their sample responded that "not being briefed before the session" made their work harder to manage.

1.5.3.3. Training

Very limited data was found on interpreters' views on training. Miller et al. (2005) reported their participants wanted more training, and more specifically an increased knowledge of: common therapy methods used in trauma work, the origin of mental health problems in RAS, emotional reactions arising in the therapeutic setting and how to deal with these, as well as strategies for self-care. Furthermore, in Doherty and colleagues' (2010) survey, attending training (e.g. counselling skills) was one of the top mentioned strategies to manage the impact of the work and respondents reported needing more training opportunities available to them.

1.6. Summary and Critique

The literature reviewed above suggests that interpreters experience a number of emotional and practical challenges related to working in therapeutic settings, and that they often draw on personal strategies to manage these, with wider support systems largely absent or inappropriate. In the literature, a variety of factors have been found to play a role in interpreters' experiences and the impact the work has on them. For example, the role interpreters perceive themselves to have or are perceived by others to have in therapeutic encounters appears to vary and would inevitably shape the experience of the work. The expected 'neutral' positioning of the interpreters and so-called 'machine' models have led to a taboo against interpreters showing emotion at work. Interpreters' shared cultural heritage with the clients they serve, as well as their own experiences of trauma, appear to be important as well. Moreover, to a lesser degree, the literature reports how employment stability and recognition from other professionals are matters of concern for some interpreters. The

profession appears to also bring personal satisfaction and growth and quantitative findings consider CS, together with empathic engagement, to potentially play a mediating role in the psychological impact of interpreting.

The literature discussed is not without limitations. Quantitative studies on the impact of interpreting appear particularly limited, as they approach the matter using specific measures aimed at quantifying predetermined psychological variables, many of which are based on psychiatric labels (e.g. ST, anxiety, depression). The lack of validity of these constructs has been harshly highlighted in recent years, as well as the dangers of measuring these variables as they were existing tangible truths rather than socially determined constructs (Rapley, Moncrieff, & Dillon, 2011). This is especially problematic since these studies have been largely completed by health professionals, whose opinion on useful constructs to investigate would likely differ from the priorities of interpreters themselves. Overall, while attempting broader generalisability, quantitative studies provide superficial information and neglect the complexity and heterogeneity of the experience of interpreters.

While the qualitative literature certainly provides a more in-depth exploration, it still approaches the matter of interpreters' experiences with very specific psychology-bound theoretical positions. For example, many researchers paid particular attention to interpreters' psychological and emotional experience which might obscure broader factors of their day-to-day experience of the work. A clear sign of such specific theoretical positioning is the extensive use of predefined psychological theories (e.g. VT, VPTG). Not only has the validity of these been criticised (e.g. VT: Schauben & Frazier, 1995), but it is likely to have limited the ways qualitative researchers have received the participants' personal and multifaceted accounts (e.g. highlighting psychological distress when having adopted the theory of VT). These constructs have also largely been generated within Western paradigms, and they are unlikely to encompass the variety of cultural understandings this multi-cultural group brings to their experience of working in therapy with RAS.

Furthermore, the majority of the qualitative literature adopts a Social Constructionist epistemology (Willig, 2013), which, while being useful in exploring participants' own socially constructed realities, limits the ways

concrete issues can be explored (e.g. the reality of the inappropriate support systems for interpreters). Also, most papers refer to experiences of interpreters working across settings (e.g. community interpreters) and provide limited information on the specificity of each setting and the perceived challenges it poses (e.g. legal, medical, psychological).

Specific research on interpreters' experience of therapy with refugees is scant and no papers were found on interpreters' experiences of support. The heterogenous challenges therapeutic settings can present interpreters with, as well as the small samples of the studies on therapeutic settings, limits the transferability of these findings. Furthermore, the majority of the studies outlined use Interpretative Phenomenological Analysis in which homogenous samples are preferred (Smith, Flower, & Larkin, 2009), which further limits their findings' applicability to other settings and contexts.

The paucity of papers identified on therapy with RAS either utilised superficial methods (e.g. using surveys or standardised measured) and/or focused on specific demographics or types of trauma. Of the seventeen qualitative papers discussed, only five focused on interpreters work in therapy. Two of these looked solely at interpreting sexual trauma stories, and one paper focused specifically on interpreters' VPTG in therapy with trauma survivors more broadly (Splevins et al, 2010). Only two qualitative papers were found that related to therapy with refugees and both are with interpreters outside of the UK (Ireland: Gomez, 2012; US: Miller et al, 2005). Many variables may change for interpreters across countries which might impact on their experience (occupational structures, make-up of the refugee population and type of therapy, to name but a few).

No study was found on interpreters' experiences of support. The studies available are facilitator-based reports of support groups offered to interpreters by mental health professionals and would be inevitably grounded in their theoretical and cultural biases. For example, such assumptions would influence what clinicians consider to be needed (e.g. supervision) and what they deem to be a positive outcome in support spaces (e.g. 'reflection' or 'sharing'). The paper by Sande (1997) is particularly problematic in this regard, as it appears to suggest that 'good support' helps refugee interpreters' to 'acculturate' and

'professionalise' in Norwegian society, largely neglecting interpreters views on the matter and overall the cultural contributions interpreters bring to refugee services. The voice of interpreters on their experiences of helpful or unhelpful support is therefore warranted.

Overall, research is scant on the experience of interpreters working in therapy with refugees and their support needs, especially in the UK. The literature identified on interpreters in therapeutic settings either adopted a restricted approach based on diagnostic criteria or focused specifically on emotional experience and VT, taking a constructionist stance. A lot of the literature also lacks specificity by looking at experiences of interpreters working across very different settings. Research specific to experiences of therapy with RAS and the support needs in this setting is urgently needed. The rationale and aims of the present study will be discussed next.

1.7. Research Aims and Rationale

The premise that working with trauma survivors can present challenges for mental health professionals is relatively well-established within Clinical Psychology (BPS, 2018). Increasing evidence suggests that interpreters working in therapy also face significant emotional and occupational obstacles but that they have poorer training and support systems (Tribe & Sanders, 2003). Work with RAS appears to be particularly hard, due to this group often having experienced extremely traumatic events and leaving their countries in sudden, unsafe circumstances, as well as facing enormous obstacles once in the country of 'refuge' (Dubus, 2015; Gartley & Due, 2017).

While the broader literature on therapeutic settings suggests interpreters may encounter practical and emotional challenges at work, literature on therapy with refugees is scant. Furthermore, literature on interpreters' experiences of support is absent across settings. Assuming interpreters are adequately served by the support tools widely used by other professions (e.g. clinical supervision) could lead to misusing resources and not meeting interpreter's needs, potentially leading to poorer quality of life and work satisfaction. As occupational stress is linked to absenteeism and people leaving their professions, interpreters are at risk of declining work on in therapeutic settings due to stress

and a lack of support available (Schaufeli, Bakker & Van Rhenen, 2009). This would be a great loss, as some languages are already poorly served, and can impact on migrants' ability to access services (NRPSI, 2019a; Equality Act, 2010).

As mentioned, the majority of the literature found drawn on specific psychological constructs when approaching interpreters' experiences. While it is inevitable for a researcher to have theoretical assumptions, and important that they are explicit about them (see sections 1.3, 2.2. 2.8 and 4.3.4), these widely used concepts are saturated with specific assumptions that might limit the way I welcome participants' own meanings. This is particularly important as a CP researcher entering the world of interpreting, which is a profession of longstanding tradition that would inevitably have its own professional constructs and beliefs on what the work in therapy and its professional support should entail.

While paying attention to the researcher's own reflexive positioning, this study therefore aims to take an open and curious approach to explore interpreters' experiences of therapy and of the support they need in this setting at different levels (e.g. individual, interpersonal, societal).

1.7.1. Research Question

The current study aims to answer the following research questions:

- 1) What are the experiences of interpreters working in therapy with RAS?**
- 2) What do interpreters identify as their support needs and how do they satisfy them?**

1.7.2. Relevance for Clinical Psychology

1.7.2.1. Occupational Well-Being

It is within the remit of CP to reduce organisational stress and promote well-being (BPS, 2014). Given the high rate of interpreters classified as refugees, this group is considered at particular risk of developing psychological distress (Tribe & Raval, 2003). This study will inform how psychologists can work with their interpreter colleagues more effectively, and how they can support them at work to prevent psychological strain and promote quality of life. Furthermore, interpreters are currently employed by public and charitable organizations which struggle to sustain themselves under the current 'austerity' programme (Unison, 2013). Research on how interpreters experience this work and the support they need could benefit them in securing funding to implement research-informed support structures.

1.7.2.2. Therapeutic Effectiveness

Moreover, studies have shown it is not uncommon for interpreters to become distressed in therapy sessions (Miller et al., 2005), and that such reactions are perceived by interpreters as impacting on the quality of their interpretation (Lai et al., 2015). This research aims to support psychologists to gain a deeper understanding of three-way emotional dynamics to inform ways of managing these in the room. Furthermore, increasing evidence is showing that interpreters are active agents in the therapeutic alliance. This research may provide further information on how to foster this three-way relationship to improve outcomes (Mirdal et al., 2012).

1.7.2.3. Power

Finally, psychologists have become increasingly aware of the power they hold in a multisystemic world and healthcare system and the responsibility they have to empower voices which may have been "demeaned" (Molle, 2012, p.51). Since interpreters work so closely with psychologists, it is important that psychologists document their experiences and push for a paradigm shift towards a greater acknowledgement of the contribution and needs of interpreters. Because of the power imbalances which often characterize the relationship between therapists and interpreters (Becher & Wieling, 2015), I

aim to minimize these by taking a non-expert approach to investigating interpreters' experiences of therapy and the support they require in this setting (more detail on the methodological steps taken can be found in section 2.8).

1.7.3. Summary

More research is warranted to understand how interpreters experience therapy with RAS and the support they need in these spaces. CP is well placed to investigate these matters and has clinical responsibilities towards interpreters and refugee clients. This study wants to start filling this gap in academic literature. The methodology used to do so will be discussed in the next chapter.

2. METHODOLOGY

2.1. Overview

This chapter outlines the philosophical underpinnings of this research, the rationale behind our choice of qualitative methodology and Thematic Analysis (TA), and finally the research methods employed. The chapter will close with a discussion of ethical and reflexivity considerations.

2.2. Philosophical Underpinnings

Epistemology is the philosophical discipline interested in knowledge and human investigation while ontology is the study of “what there is to know” in the first place (Harper & Thompson, 2012, p.4). Qualitative research is meaningless if not grounded in the researcher’s ontological and epistemological assumptions. This is particularly the case for TA since the approach is not theoretically bound and requires active and explicit epistemological choice (Willig & Stainton Rogers, 2017).

Constructionism asserts that nothing can be known as an objective truth and that such a reality as exists is socially constructed, mostly through language. At the opposite end of the spectrum, *Realism* assumes there is a direct relationship between an independent reality and our perception of it, allowing us to investigate it, as if through a one-way mirror (Willig, 2013). Nowadays, this unfiltered “mirroring” has largely been rejected (Harper, 2012, p.87). This study was framed within *Critical Realism* (CR; Bhaskar, 2008), a variant of hard-line, realist absolutism.

2.2.1. Critical Realism

CR is founded upon ontological realism, asserting the existence of the object of investigation (i.e. the subjective experience of interpreters) independently of the research investigating it. Epistemologically, CR marries the positivistic idea that we can investigate the world with the constructionist acceptance that what is accessible through research is influenced by the researcher’s interaction with the subject (Harper, 2012). According to critical realism, the world is therefore

“theory-laden, but not theory-determined” (Fletcher, 2017, p.182) and research can attempt to derive causal relationships between social events. This makes it an instructive position when investigating social issues and informing strategies for change (Fletcher, 2017). However, because events are contextually and historically placed, the data cannot explicitly reveal the causes of these complex processes. Researchers must draw on available theories to seek explanations, perhaps borrowing from other disciplines (sociology, anthropology etc.) (Harper, 2012).

CR acknowledges the researcher’s role of giving meaning to data, without denying the existence of an underlying reality. It is therefore crucial for the researcher to be as aware as possible on their own assumptions when approaching the research questions (see section 2.8) since their findings will be contingent on these ideas, rather than an ultimate truth.

2.3. Design

2.3.1. Qualitative Approach

The purpose of this study was providing an in-depth account of how interpreters experience their work in therapy with RAS and their support needs in this setting. A qualitative approach was considered the most suited to answer such questions (Willig, 2013) because it enables participants to express themselves in their own terms using their own words and because it allows the researcher to seek clarification and expansion of responses. Qualitative research has gained popularity among researchers in Psychology in recent years due to allowing for such open exploration, as authors have become increasingly aware of the limitations of quantifying complex psychological constructs (Harper & Thompson, 2012). The qualitative researcher does not try to quantify facts nor to find cause-effect relationships between variables, instead allowing for a more in-depth investigation of “how people make sense of the world” and “the meaning attributed to events” (Willig, 2013, p. 8).

2.3.1.1. Choosing an approach to analysis

While this study wanted to provide explore interpreters’ experiences, it also hoped to explore more practical matters such as interpreters’ support needs.

While phenomenological (Smith, Flowers, & Larkin, 2009) or narrative (Riessman, 1993) approaches would have provided in-depth exploration of identity, experience and personal narratives, they would have been less suited to pragmatic issues of support. As previously discussed, exploring these needs was considered crucial, due to the absence of studies available on how interpreters experience support, and TA allowed for this. Foucauldian Discourse Analysis (Arribas-Ayllon & Walkerdine, 2008) was excluded early on, since the research questions did not specifically focus on language and power.

TA was thus chosen to analyse the data in this study. This widely used and flexible method aims to “thematize meaning” (Willig, 2013, p. 68) within the dataset by “identifying, analysing, and reporting patterns (themes)” that the researcher deems meaningful in relation to their research question (Braun & Clarke, 2006, p.6).

2.4. Method

2.4.1. Semi-structured interviews

Among the variety of qualitative methods available, individual, semi-structured interviews were considered the most appropriate for this research. In semi-structured interviews participants are encouraged to provide subjective accounts in the area of enquiry, via a flexible set of questions, while also allowing for other relevant topics to naturally emerge (Willig, 2013). Individual interviews were preferred to focus groups to facilitate participants’ openness around the personal impact of their work. This was informed by the literature outlined in chapter one, indicating that interpreters may find it difficult to share their emotional struggle at work (Green, Sperlinger & Carswell, 2012; Molle, 2012). It was also a practical choice, since interpreters’ busy schedules would have made it hard to coordinate group meetings.

2.4.1.1. Interview schedule

An interview schedule was constructed based on the chosen research questions (Appendix C). More general questions were asked at the beginning to facilitate the participants easing into the interview environment and to facilitate the development of interviewer-interviewee rapport (Prior, 2017). Follow-up

questions were prepared to aid the response to general questions. For example, the question “what are the challenges of interpreting?” was often accompanied by more than one follow-up question to ensure I was not highlighting one type of “challenge” over the other (e.g. emotional over practical) but funnelling towards more specific areas of concern.

2.4.2. Involvement of interpreters

The fact that involving experts by experience in research positively influences its quality and applications has been widely documented (Domecq et al., 2014) and is considered good practice in health research (National Institute for Health Research, 2012). This was particularly relevant when investigating the experience of interpreters in therapy since the literature available has almost solely been completed by mental health professionals. I kept this in mind and made attempts to involve interpreters at all stages as detailed below.

2.4.2.1. Social media

During the design stage, a Facebook post seeking feedback on the aims, proposed methods and interview schedule was shared on four Facebook groups for professional interpreters. These posts received a limited response. One interpreter contacted me and provided more specific feedback on the schedule, via online chat. The feedback was all positive and no changes were suggested. The post was also shared on the Reddit website, where a recruiter of interpreters contacted me to thank me for bringing the issue of emotional strain in interpreters to light. Online feedback received can be found in Appendix D.

2.4.2.2. Face to face

Because of the limited time available, the changeable schedule of interpreters’ work, and the lack of common support spaces, it was hard to conduct face-to-face or group feedback sessions. I ruled out contacting individual interpreters via the same recruitment channels due to the risk of gathering feedback from the same pool who might have participated in the interviews.

However, after every interview, participants were invited to provide feedback on the interview experience and asked whether anything was missed or superfluous. All participants said the questions were comprehensive and some

thanked me for carrying out the study. The schedule therefore remained unchanged throughout the interviews. I aim to seek interpreters' views on appropriate applications of the research findings.

2.5. Data Collection

2.5.1. Participant Inclusion Criteria

The participant inclusion criteria adopted for this research were:

1. Being aged 18+
2. Having been employed as a language interpreter in psychological therapy with RAS in the UK.
3. Being able to consent and attend the interview

There were no exclusion criteria.

In this study, 'psychological therapy with RAS' referred to any therapy session involving a psychologist, counsellor or psychotherapist meeting with a client with refugee status or currently seeking asylum in Britain. This broad scope felt important as interpreters in the UK tend to work across organisations offering a variety of therapeutic approaches to RAS depending on clients' needs and service context. Focusing on one type of therapy over others would have been hard to achieve practically and from the limited literature there was no reason to believe that the therapeutic approach would influence interpreters' experience of the work and the support they receive.

2.5.2. Recruitment

Interpreters were recruited through a collaborating charity and its partner interpreters' agencies. This London-based charity offers multidisciplinary support (e.g. psychological, welfare, legal, medical) to RAS. A range of therapeutic approaches are offered by clinicians at the charity, such as CBT, counselling, integrative psychotherapy, family and group interventions. Interpreters are not permanently employed by the organisation but act as freelancers or through language agencies.

Recruitment included the three-step method discussed by MacDougall and Fudge (2001): 'prepare, contact and follow-up'. The charity was involved at the research proposal stage to ensure the proposed project met their research interests and ethics ('prepare'). When the study had been confirmed by the University of East London (UEL), a meeting was arranged (June 2019) with the charity's clinical director and interpreter coordinator, where the research and the logistics of recruitment were discussed. An email message including the Participant Invitation Letter (Appendix E) was sent to the interpreter coordinator who circulated this to all agencies and freelance interpreters working with the partnering charity ('contact'). A leaflet (Appendix F) was also placed in areas used by interpreters at the organisation's offices (e.g. reception, clinic rooms, restrooms). After a few weeks, some interpreters were also contacted by the charity via phone to ensure they had received this information. When approaching interpreters, an effort was made to achieve heterogeneity of gender, ethnicity, nationality and age to ensure the data did not focus on specific demographics.

Interpreters interested in participating contacted me via email or phone and a suitable date and location was agreed. Participants were asked at the interview stage if and how they would want to be informed of the research findings. Most consented to be sent a summary of research findings via email at completion of the project. Consultation around appropriate dissemination will be sought from consenting participants and charity representatives ('follow-up' phase).

2.5.3. Data Collection

Interviews took place in a private room at the recruitment charity, in the Psychology department at UEL and one via Skype, lasting between 45 minutes and 1.30hrs. Interviews were recorded on a portable audio recorder.

Prior to commencing the interview, the following data were collected through a questionnaire (Appendix G): Name, Age, Gender, Ethnicity, Nationality, Professional Languages. These data were needed to contextualise the sample for ensuing thematic interpretation.

2.5.4. Sample of Participants

Qualitative research does not aim for breadth and statistical significance and so as few as one participant can be a suitable sample for some qualitative studies. Sandelowski (1995, p.183) argues qualitative sample size is a “matter of judgement” based on the specificities of each research. The decision rests on a balance between being small enough for appropriate in-depth analysis of themes while being large enough to allow for wider “new and richly textured understanding of experiences”. Guest, Bunce and Johnson (2006) attempted to provide more specific guidance, based on which I aimed to recruit ten to twelve participants. Eleven interviews were completed and analysed.

2.5.4.1. Participants’ demographics

Eight women (73%) and three men (27%) participated in this study. While this sample profile is uneven, it appears to be broadly in line with the gender representation in the interpreting profession in the UK. NRPSI (2019a) reported their membership as 64% female and 36% male. Participants’ ages ranged from 39 to 71 with an average of 56 years of age. NRPSI members’ average age is 53.

Participants were heterogenous in ethnicity: Asian or British Asian (5), Black African (2), White European (2), White Other (2). Participants’ expertise covered thirteen different languages as well as English.

2.6. Ethical Considerations

The ethical considerations of this research, in line with General Data Protection Regulation (UK Research and Innovation, n.d.), and how these were acted upon are outlined in this section.

2.6.1. Informed Consent

All participants were given a detailed Participant Invitation Letter (Appendix E) explaining the study and were given a minimum of seven days to consider participating. Prior to arranging the interview, and again on the day, participants were encouraged to ask for any further clarification they needed. All participants were asked to complete a consent form on data collection and storage prior to commencing the interviews (Appendix H). It was made clear that their refusal to

participate would have no impact on their employment, to minimise any feelings of coercion. However, it is possible interpreters may have found it hard to decline the offer, wanting to protect their relationship with the recruitment organisation. Participants were informed that they could withdraw from the study at any time during the interview or up until the start of analysis, whereby it would become inextricably mixed in the iterative analytic process.

2.6.2. Confidentiality

Participants were made fully aware that the data were confidential and would only be shared with third parties if safety concerns were to arise. The interviews were taped using an encrypted audio recorder and transferred to a password-protected computer in a UEL encrypted drive. Recordings were transcribed and only shared with the project supervisor. Identifiable information was omitted from transcripts and extracts and participants were given pseudonyms. Traditionally British names were chosen, and only group demographics were provided to further protect anonymity.

Interview data and participants details will be safely stored until confirmation of degree and transcripts will be kept for three years after completion of the study, in case of publication.

2.6.3. Emotive Content

Even though risk was assessed to be low, difficult feelings may have arisen for participants during the interview. It was explained to participants verbally and in writing that they could take breaks or withdraw at any time.

Participants were offered time for debriefing and provided with relevant contacts of mental health charities should they require further support (Debriefing letter in Appendix I).

2.6.4. Reimbursement

Participants were offered a Love2shop voucher to the value of ten pounds as thanks for their participation. This felt appropriate since interpreters work freelance and they may have needed to sacrifice work in order to participate in the interview. The amount offered is far below their typical hourly rate and it was made clear that this did not constitute an inducement to participate. Three of the

interpreters donated their vouchers for charity to distribute among their in-need clients.

2.6.5. Ethical Approval

Ethical approval was obtained by the UEL School of Psychology Research Ethics committee on the 17/04/2019 (Appendix J). One amendment was granted on 18/10/2019 to allow for an interview via Skype (Appendix K).

2.7. Data Analysis

Transparency on the analysis process is of utmost importance in qualitative research for readers to be able to evaluate its results. Because of the flexibility and versatility of TA, it has faced scrutiny for its inconsistent application (Nowell, Norris, White & Moules, 2017). Braun and Clarke (2006) addressed this issue by outlining clearer steps, which have been followed in the current research, as discussed below.

2.7.1. An Inductive Approach

TA offers the choice between an inductive or theoretical approach (Braun & Clarke, 2006). This study applied an inductive or 'bottom-up' approach, whereby the researcher is interested in themes within the dataset rather than applying their pre-existent theories (as in a 'deductive' approach). To facilitate this, questions were kept open to allow participants to guide the interviewer towards themes of interest. However, because of the more practical nature of the questions around support, open questions were at times followed by more structured ones, in order to gather specific preferences on support structures (e.g. "What format would you like support meetings to have?"). While inductive TA strives to be data-driven, it is impossible to deny the influence of the researcher's own philosophy (see 2.2) and personal assumptions (see 2.8).

2.7.2. Phase 1: Familiarisation with the Data

The first phase in TA is to become familiar with the data gathered (Braun & Clarke, 2006). Because the data were collected by myself, this phase started during the interview process. Via 'prolonged engagement' with the setting (i.e. spending time with interpreters, with charity staff and in the charity environment)

I hoped to enhance 'credibility' (i.e. the accuracy of the analysis against the lived experience of interpreters; Lincoln & Guba, 1985). The reflective diary completed after each interview was useful in documenting initial reactions and thoughts on themes.

2.7.2.1. Transcription

Verbatim transcription was then undertaken. Although the value of transcription is not always recognised and may often be delegated to others, this can be a very important step in ensuring a focused reading of the material and an opportunity for researchers to "intimately familiarise themselves with the data" (Melia & Newman, 2019, p.14). Engaging in transcription can also aid a meaningful analysis, by considering participants' tone (e.g. humour or sadness) and meaningful utterances and is an occasion to reflect on the researchers' interview technique (Melia & Newman, 2019). Once transcribed, I actively read the material several times, ensuring I was familiar with the "depth and breadth of the content" (Braun & Clarke, 2006, p.16). Initial notes on trends within the data were made.

2.7.3. Phase 2: Generating Initial Codes

I subsequently focused on identifying initial 'codes' from the dataset. Codes are basic units of meaning and represent the smallest segment of data that can be meaningfully analysed. Keeping with the inductive nature of the analysis, I aimed, as much as possible, to curiously notice codes without attempting to "fit" the data into their pre-existing knowledge and assumptions (Braun & Clarke, 2006, p.12). Transcripts were coded using NVivo software. An example of a coded interview extract can be found in Appendix L.

2.7.4. Phase 3: Searching for Themes

The focus moved onto searching for overarching "themes", patterns and "central organising concepts" that appeared most "meaningful" across the coded dataset (Braun & Clarke, 2013, p.461). Codes were grouped based on such patterns, with some conveying similar meaning being merged and some that appeared less meaningful being discarded (only one code). A comprehensive list of codes can be found in Appendix M. Several code combinations were tried until an initial thematic map was created (Appendix N).

2.7.5. Phase 4: Reviewing themes

During this phase, the themes were further refined by selecting and editing the most salient themes and ensuring they appropriately represented the associated extracts, and with the goal of achieving a coherent “story of the data” (Braun & Clarke, 2006, p.21). The initial themes associated raw data and a revised thematic map (Appendix O) were then shared with the supervisor as an external reviewer of their credibility and coherence.

2.7.6. Phase 5: Defining and naming themes

Incorporating these external reflections, the next phase involved further definition of themes and their subthemes and the choice of names that appropriately captured the essence of the theme, whilst retaining as much connection to participants’ words as possible. A final thematic map was produced (Appendix P).

2.7.7. Phase 6: Producing the report

Lastly, the results section of this thesis was written up with the purpose of sharing the narrative of the data in a clear, interesting, and engaging style.

2.8. Reflexivity

In contraposition to statistical approaches, qualitative research often involves an active interaction between the researcher and the researched, as well as a subjective interpretation of the data gathered (Willig, 2013). It is therefore of utmost importance that the researcher paid appropriate attention to issues of reflexivity, that is the “critical self-reflection of the ways in which researchers’ social background, assumptions, positioning and behaviour impact on the research process” (Finlay & Gough, 2003, p.ix). Such assumptions played out in all stages of research from the initial research idea and the literature consulted, through to data collection and analysis. TA has historically had a reputation of poor quality because of a lack of transparency on subjective influence and positioning (Nowell et al., 2017). The tendency of reporting ‘themes’ as naturally emerging from the data has additionally been accused of denying the active choice the researcher (Braun & Clarke, 2006). Paying attention to reflexivity increases the trustworthiness of the results and increases awareness of the risk

of blindness towards novel information inconsistent with our pre-existing theories. While I shared in the first chapter how my own experiences have influenced my overall position on the role of interpreters and my interest in the subject, a further statement of my positioning is crucial at this stage.

I identify as a white, middle class, Italian woman. My identity is largely different from the people I interviewed, naturally impacting our spoken and unspoken interaction as well as my interpretation of their subjective accounts. While I share a migrant identity and multilingualism, my experience as a tertiary-educated economic migrant from a European country would likely be very different from those of the participants.

I am also a Trainee Clinical Psychologist (TCP) and have had extensive training in the field of psychology shaping my worldview. This discipline has historically focused on serving and being informed by a White western population (Patel & Keval, 2018). Again, this is likely to differ from my sample's heterogenous cultural understandings. My epistemological and ontological standpoints are very likely to be influenced by those most prevalent at my institute of study, favouring systemic, critical approaches and qualitative research.

TCPs are clinicians and researchers. While this duality poses several advantages (such as an increased knowledge on research's clinical relevance and application), these two different 'hats' are not always reconcilable. Even though it is recommended that TCP hold an integrated profile, there is always the risk of the researcher gravitating towards the "work identity" they are more comfortable with (in my case, the therapist) (Yanos & Ziedonis, 2006, p.3). For example, it may be harder for a TCP to resist the pull towards validating interpreters' experiences or of normalising distress (e.g. by saying "other interpreters shared feeling sad about the client") with the risk of influencing participants' responses. Furthermore, conflicts of interests may arise between what the clinician thinks is best for the population they clinically serve and the most relevant trends within the dataset (Yanos & Ziedonis, 2006).

As a TCP investigating experiences of therapy, power dynamics would inevitably be carried across, recalling therapists being the more powerful presence in the therapeutic encounter. Steps were taken to minimise such power imbalances: posing questions curiously, from a non-expert position;

making it explicit that I did not know the answers myself (e.g. “I wouldn’t know because I am not an interpreter”); avoiding psychological constructs (e.g. ‘trauma’ or ‘burn out’); and being guided by the participants’ own understanding and labels for their experiences. Asking for feedback was also a powerful tool in ‘stepping down’ and acknowledging I had a lot to learn from my participants. Despite these steps, it is likely that such power dynamics influenced participants’ ability to talk openly to a certain extent, given interpreters’ documented wariness to discuss their struggles at work (Green et al., 2012; Molle, 2012).

2.8.1. Ensuring Quality and Reflection

In arguing for TA to be better recognised, the variance in methodological quality has been a matter of contention (Nowell et al., 2017). To ensure this research maintained quality and transparency, its processes were monitored and reviewed via the following methods.

2.8.1.1. Reflective diary

Reflective notes were taken after each interview, comprising relational dynamics during the interview, personal assumptions noted, when these were challenged, and initial thoughts on prevalent themes. An extract can be found in Appendix Q.

2.8.1.2. Peer and supervisory support

Authors suggest triangulation of analysis (i.e. the use of several methods or researchers) is the best way to ensure ‘credibility’ in qualitative research (Spencer & Ritchie, 2012). While this was not possible with the time and resources available, I still relied on reflections with other researchers to protect methodological integrity. Supervisory meetings and feedback were key in ensuring this dialogue at every stage. Regular meetings were also held with a fellow TA researcher, to discuss initial thoughts on themes, interview processes and reflexivity matters.

2.8.1.3. Audit trail

To increase personal awareness of the research process and its transparency, a detailed audit trail was kept, and some of this documentation has been

included in the appendices (coded transcript extract [L], list of codes [M], three stages of development of the thematic map [N, O, P]).

2.8.1.4. Participants' feedback

As previously mentioned, participant's feedback was sought at the end of every interview around appropriateness of the research schedule and interviewing style. Feedback on the themes identified will be sought from consenting participants prior preparing for publication of the results.

2.9. Summary

This section has explained this study's CR epistemological framework, the selection of semi-structured interviews as a suitable data collection method, the TA analytic approach, the rationale behind these choices and the execution thereof. It has also discussed ethical issues that were encountered and how these were managed. Finally, I presented a statement of my reflexive positioning as well as structures implemented to ensure reflexivity and quality throughout the research process.

3. RESULTS

This chapter will begin by providing an overview of the themes identified through the analysis before focusing on a more detailed exploration through extracts of participants' accounts.

3.1. Overview

The process of TA was not straightforward due to the heterogeneity of the data and experiences of participants. Bipolar themes (e.g. "Just the Words vs Going Beyond") were chosen to account for such differences and nuances. Three main themes were identified, each of which included four subthemes, as outlined in the table below.

Theme	Sub-Themes
1. What is my Role?	1.1. Trust and Confidentiality in Political Context 1.2. Negotiating Cultural Boundaries 1.3. The Challenges of Interpreting in Therapy 1.4. Just the Words vs Going Beyond
2. Emotionally Connected vs Detached	2.1. "It Wears You Down" 2.2. Sharing Humanity 2.3. Being Strong / Switching off to Survive 2.4. Maintaining the Balance
3. Current Context vs Aspiration	3.1. Precarity and the Profession 3.2. Dealing with Things Alone vs Receiving Personalised Support 3.3. Being "Just" the Interpreter vs Being Trusted, Valued and Included 3.4. Purpose and Growth

3.2. Theme One: What is my Role?

This first theme focuses on interpreters' understanding of their role in therapy and its perceived challenges. A strong sense of ambiguity in the role was noticed with contradictions between and within participants' accounts. We will explore each sub-theme in turn.

3.2.1. Trust and Confidentiality in Political Contexts

Trust and confidentiality were identified as important and interconnected subjects. For most participants, trust was considered paramount for the client to be able to “open up”, feel “safe”, and engage with the therapeutic process. However, such trust was described as particularly hard to achieve with RAS:

Alistar: If [the clients] don't trust you, they're not going to tell you anything. Some of them is political issue, some of them they come here... to hide from whatever looking for them. If you don't keep them safe, they're not going to trust you.

Building trust was considered a particularly delicate matter when the client fears the interpreter's political alignment or relationship with abusive governments. Andrea described making it explicit that she does not support the oppressive majority group she ethnically belongs to, in order to foster a safe space with clients from an oppressed minority group:

Andrea: I know a [Middle Eastern minority] client may not feel at ease with me, with my way of speaking [Middle Eastern language], with my look it gives away, but that's again I think I can convey that I'm not a nationalist at all... when I translate “[Politically Contentious State]” as “[Politically Contentious State]” it is very clearly understood that I don't have any qualms, that I recognise it and I don't see the [majority group] cultures above the [minority group].

Trust in the interpreter's confidentiality was perceived to be threatened not only by the interpreter being part of oppressive ‘other’ groups, but also by them belonging to the same close-knit community. Cultural stigma further complicated such mistrust:

George: Especially if it's of sexual nature, they're embarrassed to discuss it, in case I discuss it with another member of the community.

Building upon these challenges, Francis described this adding complexity to confidentiality in the interpreter-client relationship where politics may not always be divided by community:

Francis: Many of my [African] clients absolutely adamantly refuse an African interpreter, because they're concerned about confidentiality, which is unfair, because it's assuming [they are] going to break

confidentiality... don't make an assumption that they're going to be happy because you've got them someone from their culture, you need to explore that and then it's a minefield, are they going to be of the same political backgrounds, or... opposite sides?

Confidentiality was seen as particularly important in therapy, because of the “intimacy” of the content discussed. Helena described how she extends confidentiality to reflecting upon the material discussed in sessions:

Helena: it's such intimate stuff that belongs to that person. It doesn't belong to me. I don't feel I have the right to take that with me.

Gaining the client's trust (or not being trusted) also appeared to have consequences on the interpreter's experience and their job satisfaction:

Anna: The thing that I enjoy most about is knowing that people trust me and I feel that people that I work with know are sure that ... they can trust me that whatever is said in the room, it stays in the room.

Alistar: It s quite difficult when you are first in that kind of situation and you think... "I don't have anything to do with the government", but I don't want people to look at me like "ah, he is here just to spy me".

Maintaining such trusting relationships seemed to require a delicate and culturally sensitive negotiation of boundaries, developed in the next sub-theme.

3.2.2. Negotiating Cultural Boundaries

The second sub-theme of ‘What is my Role?’ refers to the negotiation of boundaries with clients, as well as the pivotal role ‘bridging’ cultural boundaries between clients and therapists.

Most participants described challenges in handling relationships with their clients, especially during the interactions *outside* the therapy room (e.g. in the waiting area), where clients frequently seek further support and contact. Some interpreters appear to stick to more rigid boundaries. There was acknowledgment of the risk of unintended therapeutic input and that such a line should not be crossed due to not being “allowed” (e.g. Amy) or due to potentially hindering the effectiveness of therapy (e.g. Anna):

Anna: I have made such a huge effort compared to other settings to... never talk to the client [outside the session] and to not to leave at the same time. I [don't] want any therapy to happen outside... I want to make sure that their therapy is done 100% right... in the right place, stuck to very strict boundaries.

Amy: It becomes a bit awkward, sometimes the patient wants to talk more about what's happened, but I'm not allowed to speak to them alone without the professional being there, so I try to avoid that.

Some participants found these interactions harder than others, and cultural customs added a layer of complexity. Andrea talked about getting used to saying 'no' to sharing personal information in a professional setting:

Andrea: it is a learnt thing for my community... and I was finding this very difficult in my first years in this country when I'm doing translation because like not answering your question is rude. Whereas it is not, it is just boundary and preserving yourself and the other person.

A minority of participants found it easier, using strategies to communicate that they did not want to interact on a personal level (e.g. moving the conversation to more neutral topics). Sylvia described trusting her clients to distinguish the nature of their relationship based on settings:

Sylvia: I think we are looking down on people too much, we don't think they have the ability to distinguish the difference. Especially [Asian], they do. We say 'your inches and metres'. In other words, you know how to behave from one place to the other.

Some participants communicated feeling like boundaries were imposed and monitored by *higher structures*:

Andrea: I have been seen chatting to clients outside and of course very rightly so, they want to know, they need to know if I'm observing the boundaries.

Sylvia: [Talking about remaining in contact with a family she used to work with] It's this friendship, isn't it? So who says I cannot make friends with them? Is the organisation going to stop me making friends with them?

All participants agreed that providing input on culture is one of their core duties. While some deemed this to be strictly necessary to ensure accuracy of translation, others went beyond and provided further information around cultural understandings and stigma. This brokering was considered particularly important when clients come from communities where therapy is not popular:

Margaret: in my country... they don't know what counselling is and when I say you will have counselling, they don't understand it... So I asked. "in my country, a lot of people they don't know what counselling is, will you please explain to me?"... they explain everything to me and then I start explaining to the customer, that's what I do.

Interpreting psychological constructs for clients coming from contexts where Western psychological therapy is less familiar was also one of the specific challenges of this setting, as discussed in the next sub-theme.

3.2.3. The Challenges of Interpreting in Therapy

'The Challenges of Interpreting in Therapy' is the third sub-theme of 'What is my Role?'. As all participants had experience of interpreting in a variety of settings (mostly medical and legal), all of them referred to the specific challenges of therapy with RAS, compared to other settings. The quote by Sarah below highlights three challenges which were frequently mentioned in interviews: interpreting for someone who is in psychological distress, the terminology needed, and the difficult material that is often shared in sessions with refugees:

Sarah: In therapy sessions... it's never easy because the service users would be vulnerable within themselves... [and] it's quite demanding as the terminology have to be precise... but also respecting their mood swings, and sometimes they don't want to talk. I have to cater for everything. In addition to the very stressing scenarios that can appear.

Beatrice also highlighted the challenges of presenting information "the way they mean it" in an environment that is "highly charged emotionally" and some participants described requiring specific interpersonal skills to support people in emotional distress:

Alistar: I use my experience and tactic on how to work with mental health people which is the way you are talking to them and the way you are approaching them.

Most participants discussed technical challenges therapy with RAS can pose, such as the extended concentration required to interpret in therapy sessions:

Francis: Counselling sessions last an hour, most medical interpreting... is going to be anywhere between 15-20 minutes... it's not usually sustained over an hour. So it's taxing, it's quite tiring.

Some also referred to therapy having specific technical rules to be followed such as the “seating system” and “how you look to the person” (Margaret).

Many participants expressed difficulty working with psychological terminology, not only because therapists “are prone to use idioms” (Francis) but because psychological vocabulary does not have direct translations in all languages. Amy and others specifically mention the complexity of translating outcome measures:

Amy: it's really hard to interpret in [south Asian language] because there are no words to describe things about someone's mental health. There's a sheet that you tick the boxes and the scales 1 to 10... sometimes it could be difficult, they are thinking “what is this?” and that part is hard because you want to get an accurate picture of someone's mental health in a week or two.

Another perceived struggle was not having the background and training to understand the context of the therapeutic interaction and the techniques employed, and how this can leave the interpreter feeling both confused and distracted:

Francis: [Talking about a therapist reflecting back what she had heard from the client] I was thinking “for goodness sake he just told you! Why do you need him to repeat all the time?” and then one day, another psychotherapist... explained about reflecting. “Aaaaah, that's what she was doing!” Right, so she was doing it because it's her method but I didn't understand... and it was distracting me, it was disturbing me.

Participants raised the ‘invisibility’ required of them in sessions, with some finding this position hard to maintain in a therapy setting. Beatrice refers to such a stance as necessary:

Beatrice: You're not there to intervene, you're not there to direct or steer the course of the thing. Because if you do that, then you're not

doing your job properly. Your job is to assist the professional and to facilitate that meeting smoothly without you being in the way.

Andrea discussed how the intimacy of a therapy setting sometimes leads her to worry whether she is “*too much in the room between two people*” but highlighted how the ‘invisibility’ expected of her can be hard:

Andrea: The client sometimes feels sceptical [about completing outcome measures] and I feel weirdly like dutiful that I should be questioning and also I want to convey their tiredness but then again I remember my job is not that.

The pull of some participants to leave invisibly behind and go beyond their linguistic role is expanded upon in the next subtheme.

3.2.4. Just the Words vs Going Beyond

This fourth subtheme of ‘What is my Role?’ refers to the ambiguity of the interpreting role and the views interpreters hold on its reach. This bipolar theme was chosen after noticing that participants’ views were polarised between those who welcome having a relationship with the client and carrying out extra duties to support them practically and emotionally, and those who mostly stick to conveying the words only. However, an element of inconsistency was noted within some participants’ accounts, with some initially saying their role was exclusively to interpret language, but then describing other duties they find themselves carrying out in the therapeutic encounter (e.g. cultural mediation). This may indicate an inner conflict of feeling pulled towards the metaphorical wearing of different ‘hats’ to support client and providers.

George extensively discussed how sticking to language interpretation and that building a personal rapport with the client on a personal level might negatively impact his interpretation and ‘neutral’ positioning:

George: They might start telling me about the incident to influence my interpretation... and I might develop sympathy towards them and therefore not interpret what they say.

Francis also mentioned the importance of remaining neutral, going on to describe how hard this is to achieve (provoking “*turmoil*”) and how interpreters’

empathy for the client may lead to being “advocates”, especially in the intimacy of a therapy setting:

Francis: As interpreters, we have to be impartial and neutral and that is easy to understand but it is very hard to do... you empathise, you feel sorry for the client... but all the time you are struggling to remain impartial and not to go beyond the boundaries of your role.

Most contested the notion one must stay hidden and not connect with the client:

Sylvia: The only one... they can trust is the therapist and the interpreter... so if you are still very cold, how can they trust the whole world? There is no way, you need to have trust to do the therapy so then you need to let them think that I am still trustworthy, even outside of therapy room.

While Andrea described finding empathy and connection crucial in her work, she reports how she is at times conflicted due to worrying that her ‘connected’ presence might be a “burden” to the client:

Andrea: is my presence too much for that person?... Because sometimes they talk to me outside here... we will have hugged each other. So I am mindful and keep thinking in the background that this closeness or warmth is a burden for them, preventing maybe some very shameful things in front of me, can they say or not?

Most participants talked about the importance of ‘being human’ towards the client, of showing empathy and generally agreeing to be flexible with the boundaries of their role to help vulnerable clients:

Anna: [talking about being asked to help a disorientated client find their way to the session] So you think, okay, you could be a harsh interpreter and say I'm sorry, I'm just not going to do that or you could step in their shoes and think I understand and then it's okay, I'll meet you at the station and we can walk ten minutes.

Some described an inner dilemma whereby they feel that some tasks are not ‘their job’ (e.g. looking at letters outside contracted hours) but agree to take them on, due to a sense of moral duty. When referring to the isolated life of many clients, I had the impression some participants at times felt ‘cornered’ by knowing such services will not be offered by anyone else.

Furthermore, many participants describe playing an important role in facilitating engagement between the client and the therapist/provider. Alistar provided an example of facilitating the engagement of a client on a ward:

Alistar: The professionals asked me “how did you do it? what did you say to him?”... I said “he lost trust in you, I don’t know what kind of injection you gave to him. I believe it is to help him but he doesn’t think it’s going to... He believes you are going to kill him and I explained to him “they are not here to kill you”, that’s all, it’s not magic... but they were impressed!

It is interesting, although perhaps not unsurprising, to note that participants’ approach to their work (linguistic or relational) tended to reflect whether they value detachment (linguistic) or emotional connection (relational) in their work, as described in theme two below.

3.3. Theme Two: Emotionally Connected vs Detached

This second overarching theme is concerned with the emotional consequences of the work, the strategies interpreters employ to manage these, and the emotional investment interpreters described having in their work. A bipolar theme was chosen here in order to illustrate the presence of two distinct positions (i.e. connected or detached) participants took and their oscillation within these.

3.3.1. “It Wears You Down”

This theme refers to the interpreting job being described by most participants as difficult to manage emotionally in the long run, or as negatively impacting on the interpreters’ overall view of the world. Many discussed the effects interpreting difficult material can have on one’s emotional life:

Sarah: all of the cases are challenging: victims of torture, trafficking, domestic abuse. They are all, in their own way, emotionally draining

Some participants, describe this impact as happening slowly and “silently” and not necessarily being felt intensely during or after sessions:

Helena: sometimes you have also unwanted thoughts from the stories you hear... and you need to learn how to quickly push them away and

not ever dwell on them but it happens because we hear terrible things. And year after year, it becomes almost normal in the session you hear these things and somehow your brain registers everything whether you want it or not, at some point there will be thoughts and truly bad stuff and things that you would have never perhaps imagined before you ever did this kind of work.

Others relayed not being fully aware of how much the job was having an impact on them until people in their network notice:

Francis: my wife... let me rant but she was very concerned, I remember her saying to me: "are you sure you should do as much of this kind of work, because I'm worried that it's affecting you".

Some participants also described interpreting refugees' stories as affecting their overall worldview, leaving them more "pessimistic" (Andrea) and questioning whether the world is a "safe place" (Helena):

Andrea: I am eternally sad and angry with what's been happening almost all over the world ... seeing and hearing first-hand what I know from newspapers, it is adding to this despair.

Three participants (Beatrice, Amy and George) are an exception, not finding their profession to have negative consequences on their emotional life. They describe feeling completely able to 'leave work at work', using "switching off" strategies', and focusing on the translation, without emotionally processing the material.

Beatrice: for us, interpreters, it's in the ear out of the mouth and the other way, both sides, so nothing retains here [pointing at her head].

Their experience is also not represented in the next subtheme, focused on a more emotionally present approach to interpreting.

3.3.2. Sharing Humanity

This second subtheme of 'Emotionally Connected vs Detached' refers to the accounts of interpreters 'being human' and hurting alongside the client. Alistar, alongside others, discussed the pain experienced identifying with the client:

Alistar: Sometimes my tongue becomes heavy even to say it. When you are repeating what you heard sometimes you are feeling like it is

happening to you or to one of your family members, that kind of emotion you feel straight away.

Andrea provides an example of crying in session and how, even though initially worried it was inappropriate, she was pleased that the client and therapist welcomed her emotion in a shared moment of humanity:

Andrea: I just felt this this longing of his father then I saw my teardrop on the floor and I thought "shit, it's not my grieving, it is his" and "pick up yourself". So without them seeing I was trying to wipe and I thought maybe the therapist will tell me afterwards and no it wasn't. He just put his hand and checked with me how I am and it was so human. It wasn't a breach of professionalism, so nobody made me feel that way at least not the young person and not the therapist.

Some participants highlighted how the technique often requested in therapy of using "I" and embodying emotion may make interpreters more prone to hurt with the client:

Francis: because when we interpret we use first person, we use "I", we not only hear it first, but then we relate it in the first person as if it was me... We are much more prone to vicarious traumatising, because we have to say it in a similar tone of sadness or pain or whatever it may be. So we're living it in a kind of proxy way... I think to some extent we're actors ... To do it, right, you've got to match the tone so you have got to adopt the emotion, you're taking it inside.... you are not Google Translate on legs, you're a human being. If you reflect the emotion, I believe at least, you have to adopt the emotion, so then what do you do with it?

Helena also highlights below how important it can be to "suffer along with the client" to convey their feeling:

Helena: It's good to relate and maybe even to suffer a little bit along with your client because you do better work... because the empathy is very important because the client is desperate to be heard... so you are the voice if they can't speak the language directly, what they're conveying is the hurt a lot of the times and that has to be transmitted.

Feeling what the client has been through is reported to be especially hard for interpreters sharing a forced migration background. Anna described the

challenges of interpreting for co-nationals, while the war in their home country was ongoing:

Anna: For me it was very emotional because [Eastern European Country] was going through a war... our families were... still back home. So you hear these horror stories happening and you think okay, this could happen tomorrow to my brother or to my parents.

Additionally, Margaret shares the emotional impact her job has and how it can bring back difficult memories of her own migration to the UK:

Margaret: when I go home I start crying, the problems you had on the road, come from your country you are always thinking what happened to your country.

It is however important to mention that, although emotionally hard, sharing a similar background as the client was overall discussed as positively affecting the participants' work as interpreters (e.g. being able to put themselves "in their shoes", trusting they will eventually be "okay").

While it was generally acknowledged that people with forced migration backgrounds were more likely to identify with RAS clients, participants from different backgrounds also shared hurting for aspects of the clients' experiences that they could relate to:

Francis: some of what the clients say sometimes really kind of resonates, which is weird, when you get a black African guy or a woman relating something and you've got this white [European] guy, and you think, how could he possibly understand what I'm saying? And actually, it is quite possible that you understand it very, very well, because it's not a million miles from what you've been through.

It was noted that these identification processes appear to bring up conflict and even guilt for some of the participants, with a repeated refrain being that "the trauma is not theirs to feel". This overlaps with the next theme on the narratives around having to be strong and hide their emotional selves.

3.3.3. Being Strong/Switching off to Survive

The third subtheme of 'Emotionally Connected vs Detached' focuses on participants' perceived need to be "strong", "professional" and not to "break

down” when interpreting difficult material discussed in session. Most participants mentioned relying on detaching, “switching off” or distancing strategies, either within the session or after, as the only way to cope with, or “survive”, the experience:

Sarah: None of the cases are easy. There being domestic abuse, torture rape, victims of torture, you just name it, they're all equally the same. But I try once I leave the session... I distance myself... otherwise, I would kill myself⁸.

In the quote below, George discusses employing ‘detaching’ in his work and how physically looking away from the client helps him achieve this emotional distance:

George: I can switch off ... I look straight away at the judge or the therapist. That technique I have realized helps me because I'm only interpreting the voice...I don't get carried away and get emotional because I don't see the tears in their eyes and their facial expression.

Managing their emotional reactions in the session was described by many participants as being “strong” for the client:

Alistar: if I am too emotional, I am not helping the person, I have to be strong more than the person.

For many, being “strong” and “professional” was equated with not showing emotion, with some worried that emotion would get in the way of them being able to carry out their interpreting duties:

Amy: I work very professionally, I try to block out the emotion... I try not to show that my side of emotions or any sort of facial expressions or body language to show that I've been affected by it because otherwise I won't be able to do my job properly.

⁸ Sarah was offered debriefing after the interview and was provided with contacts if she was to need psychological support in the future. Despite such a strong statement, she did not appear unsettled during the interview and described having developed coping strategies to manage the impact of her work.

Sarah: As an interpreter, I don't think it would be professional to express my emotions. So I don't portray that no matter how sorry I feel for the service user, how sympathetic I am with the person... I try to distance myself so I bottle my emotions.

There appeared to be a tension between this subtheme and the prior ('Being Human with the Client') with many participants considering emotions to be "human" and important in providing quality interpreting but then describing anxiety around displaying them. I felt like this raised an implicit question: "how much feeling is too much?"

For example, when discussing the support offered to interpreters, some participants (including those advocating for a more emotionally connected approach) shared feeling embarrassed about receiving emotional support and that opening up about their experiences made them feel vulnerable:

Andrea: Maybe I wouldn't come for example if the organisation provided one [talking about a support space for interpreter] because it feels naked. I don't know maybe it's a primitive thought... maybe I wouldn't want to show that so-called "weak" [in 'air quotes'] side of me.

Only one participant (Beatrice) reported not requiring distancing strategies to avoid feeling emotionally affected and viewed her job as not involving any kind of emotional processing ("in ear out of mouth"). However, given that most participants found the work stressful, there was an emphasis on looking for more adaptive ways of managing the work, such as 'maintaining a balance', which will be explored next.

3.3.4. Maintaining the Balance

This last sub-theme of 'Emotionally Connected vs Detached' refers to a series of strategies participants reported using to practice self-care, maintain balance in their lives and limit the consequences their job can have on their day-to-day life. Most participants mentioned, alongside personal coping strategies, trying to limit the amount of work they do in the therapy field, and combining it with jobs in less emotionally demanding settings:

Francis: [at the beginning of my career I had a stern talk with myself... if I want to continue to be an interpreter, I'm going to have to find strategies whereby I can cope with it.

Helena: I don't think it is healthy to go on too long and to do only this type of work, you need to... diversify... [do] other things that have nothing to do with this type of work.

Beatrice: [while talking about why she does not feel emotionally affected] It's the makeup of the workload that comes, it does make a difference because I don't [exclusively] do therapy.

In the quotes below participants describe various strategies they employed to maintain the “balance” and switch off from their professional demands/role such as exercise, music, walking or talking to trusted people in their network.

Sylvia: I go into my garden, do my exercises, and play the piano

Sarah: I do meditation, mindfulness, yoga.

Andrea: I try to come here fresh ... I keep my day clean and not riddled with problems. If possible, I walk here or come with a nice means of transport like top side of bus. So I come here, enjoying myself and clean clothes, take a shower... and afterwards, if something touched me.... maybe I tell my friends... about my joy or about my sadness.

Some participants highlighted the importance of having people in their social network notice that they need support or distraction. Margaret reported that her son often notices when she has been working in therapy sessions:

Margaret: [My son says] “today something has happened maybe because today you were going to the therapy” “that’s right” and he was telling me “don’t bring it home, when you come home just enjoy”.

Interpreters described the aforementioned personal strategies they use to ‘maintain the balance’, but their ‘aspiration’ would be combining these with better support from the systems around them.

3.4. Theme Three: Current Context vs Aspiration

The third theme relates to the current professional context interpreters find themselves in, what gives them purpose, and aspirations for their professional future. A bipolar theme was chosen here to describe experiences across this time continuum. The ‘today’ participants describe is largely one of instability, low

pay and poor support. 'Tomorrow', most participants would like more support and protection, even though they hold varying views of what these should look like.

3.4.1. Precarity and the Profession

Overall, the interpreting profession was described as unstable and poorly regulated or protected. Though the majority felt strongly that the employment conditions should be different, a minority of the participants accepted that this as the nature of 'freelance work' and shared choosing the job specifically for the flexibility it allows.

An issue all participants agreed on was the low wages interpreters receive, with several participants describing working for "peanuts". Helena below describes how she thinks it is virtually impossible to live off your salary as an interpreter and how much stress this can provoke:

Helena: You can't [survive on an interpreter's salary], or you need to do like some interpreters do here... they stress themselves to death. They run around from one job to the other in order to get a decent amount at the end month.

During the interviews, I perceived a strong sense of disappointment when pay was discussed and how such low wages made participants feel underappreciated, in a job that is technically and emotionally demanding. Low pay was described as the result of a low hourly rate, compounded by how the work was organised, with jobs occurring 'here and there' at inconvenient times and in different locations, making it hard to have a full and consolidated day of work.

All participants raised managing their schedule 'on the go' as hard and how not missing any appointments and arriving on time required focus and organisation. It was also frequent for jobs to be cancelled 24hrs in advance, without pay. I had the sense that pay negotiations could be difficult, with many interpreters arguing with providers to ensure minimum employment standards. For example, Alistar communicated real frustration with the unfairness of having to argue for long-distance travel reimbursement:

Alistar: The money I am using it's just for petrol! I want to do the job! It is just for travelling that's all I need.

It was discussed that work schedules can reflect particular customs of the communities the interpreter serves, such as having less work and subsequently less income during Ramadan, due to Muslim clients having fewer appointments. Amy described how precarious and irregular hours impacted her sense of self-satisfaction and triggered feelings of guilt about not doing 'enough':

Amy: I feel a bit bad guilty that I didn't do nothing with people out there actually done a whole day's job going home now and I've done nothing and not earned anything. There's a bit of guilt there, feeling that I have not achieved anything.

Another common point raised was the lack of employment benefits such as holiday or sick pay, as mentioned by Sarah and Alistar below:

Sarah: I'm not an employee of any organisation sadly, so yes I'm not protected we don't get any pension. I get a salary and that's the only thing I get, so in a way no we're not protected.

Alistar: They have to do something because that's our main job. Sometimes when I am travelling when I am going on holiday, I know I will come back and won't have an income, I have to start working from zero so my wife steps in to cover.

Beatrice is an exception to these narratives. While she recognises the lack of job security in the profession, she describes feeling satisfied with trading such stability with the "freedom" interpreting allows her:

Beatrice: If you take time off, you don't get paid. If you're ill you don't get paid, the irregular hours, all sorts of things, but then I don't know people get into freelancing work for different reasons. For me, it's freedom. I just value it above everything else.

Furthermore, many participants addressed the fact that interpreting is not a regulated profession and how this impacted the overall level of support, as well as potentially contributing to declining quality of services.

Francis: However, the problem is that interpreting in the UK is not a recognised profession. So it's not regulated and does not have

protection of title, so as a result, unqualified people can work as interpreters and do a lot

Poor regulation appears to result in skilled and trained interpreters feeling undervalued, with some of them sharing concerns that untrained interpreters make them “*look bad*” (Amy) and impact upon the reputation of the profession. Many discussed how having an overarching body would help them to feel supported, and would also allow for representatives to advocate for better working conditions for interpreters, which agencies are considered unable to do:

Andrea: I don't know if there is any union or a body... that looks after and responds queries from interpreters, fights for our right.

Many participants felt that the profession was in decline, with some worrying that they will be replaced by technological advances and that interpreting does not have the “*appeal and glamour*” (Helena) that it used to have. Some participants thought that improving the profession is not “*high on anyone's agenda*” (Francis) and that this is reflected in public spending priorities. Such concerns were extended to charities interpreters work for, with some saying that more support for interpreters would be “*impossible*” or “*a dream*” because of the financial limitations of these organisations. Some participants reflected on the impact of the current political climate focused on increasing the barriers to immigration, as not being an environment in which their profession can flourish.

Participants appeared isolated in their thoughts around lack of professional identity and protection and these fed into their discussions around how best to manage any potential support.

3.4.2. Dealing with Things Alone vs Receiving Personalised Support in Safe Spaces

The second subtheme of ‘Current Context vs Aspiration’ is concerned with the support systems for interpreters. All participants described formal support as being virtually non-existent and how interpreters are mostly left to ‘carry on’, finding their own ways of dealing with things on their own:

Sarah: Do you want me to be very honest?... hardly existing sadly.

Researcher: What is there?

Sarah: Nothing!

When asked where they would seek support if they were to need it, most participants replied that they would simply 'keep going' and "carry the burden" (Helena), and that they would access NHS mental health services if experiencing severe distress. A minority said they would approach a therapist that they trusted in the workplace.

Most participants described interpreters working in therapy with RAS as needing specialised support compared to other settings, due to the particularly emotive nature of the work and the technical challenges. This was considered crucial not only to promote interpreters' well-being, but also to improve the quality of the services they offered and to "monitor" their "safety" and fitness to work:

Helena: it would certainly help in keeping you stable to do better work ... the content here is pretty extreme... out of this world. It does affect you whether you think of it... and you need to be kept safe. The same way that clinicians are being kept safe.

As in the above quotation, frequent references were made to interpreters receiving 'what therapists get'. The awareness of therapists' formal supervision spaces raised a sense of perceived inequality between the professions.

Most participants also mentioned the dilemma, wherein they could not discuss material from sessions with people in their personal lives due to confidentiality but did not have any other reflection space. I noticed a real sense of absoluteness in interpreters' application of confidentiality, whereby they did not feel able to discuss such issues with anyone, not even by anonymising the material:

Helena: who do you talk to? you can't go home and talk to your family about it... we're not even supposed to speak about our clients.

It was hypothesised that the lack of spaces where it was permissible to talk openly might contribute to such a strict approach to confidentiality.

While most participants agreed that support systems should be improved, they disagreed in what form this should take. Only one participant (Beatrice) thought

she did not require improved support systems, due to trusting her personal strategies to manage her work-life balance.

Most participants talked about spaces for dialogue and reflection, either one to one (e.g. via debriefings or meetings with the clinician) or in a group with other interpreters. Such exchanges were mostly described as being facilitated by an 'expert', most imagined this being a mental health professional or, for a minority of participants, an interpreter experienced in working in therapy.

A minority conceptualised support in terms of increased learning opportunities for interpreters via formal training in mental health or opportunities for interpreters to learn 'tips' from one another (e.g. seminars or a newsletter):

Margaret: when you have training, you have more knowledge? For example, if you are a doctor, he can't continue without reading a new research. So we have to continue a new system and new things and new words.

Notably, the participants taking a more technical and less relational approach to their work valued training, while interpreters adopting a more relationally present stance sought increased spaces for reflection:

Helena: There should be something available at least a few times a year or the possibility of accessing a clinician, one to one... and then there should be like a support group that meets regularly.

Participants were overall in agreement on the fact that any support offered to interpreters could not be "one size fits all" and that options should be offered to fit the variety of work and lifestyle arrangements of interpreters:

Sarah: Maybe more of a mix and match, for example, every few months, one on a one-to-one basis... different people react differently to situations. For example, group sessions, and maybe a scope to learn new skills.

Some participants discussed group support spaces in the past, where they had felt exposed, and mentioned the importance of feeling safe in support environments:

Andrea: sometimes... you don't feel comfortable to talk because there is a clash of interest or lack of trust, because we all swear to

confidentiality but then you don't know how it plays out on site and also it was kind of strange because it was in the same building even next to the managers' room. So the physical environment matters very much.

Some participants mentioned support spaces as being unsuccessful in the past due to lacking such flexibility or being tokenistic and not “thought through”.

Some participants also raised the issue of paying to access support spaces and how this had been a financial barrier. Amy discussed how she was unsure whether she would access a support space even if it was arranged due to the cost and travel she imagined this would involve:

Amy: There is a cost and issue there. I wouldn't.. I am sorry to say this... if I was to go somewhere South London I wouldn't bother.. spending my travel expense and time.

When I asked whether participants thought they should be paid to attend supervision spaces, participants said they should, but most described this as being “ideal” or “a dream”, with some even reacting with laughter.

While advocating for better formal structures, many participants valued being informally approached by clinicians or organisations' staff to ask how they were; and being offered time to ‘debrief’. Being kept in mind in the therapeutic space was seen as supportive:

Sylvia: After a particularly sad or dramatic session, she can just say if you need to talk, we can. I can give you a bit of time and we can talk...just by saying it might be already easing up that feeling.

Finally, some participants referred to finding regular briefings and debriefings helpful to have a moment of dialogue, reflection, and togetherness with the therapist:

Anna: it was important for us to have a few minutes together after the session, because [the session] was very distressing.

As discussed in the next theme, such need for belonging and togetherness with therapists, clients and hiring organisations is something most participants aspired to, with some mentioning sometimes feeling “just the interpreter”.

3.4.3. Being “Just” the Interpreter vs Being Trusted, Valued and Included

This subtheme refers to how important participants find being valued and included by therapists and clients, rather than being seen as peripheral external agents to the therapeutic encounter:

Amy: We're not seen as someone in a professional level... we are not taken seriously. I have felt that by professionals at times, that we're not so important. We are just an interpreter we just translate the word, but it's not just about being the word to word ... quite complex things... I have to understand what's been said, you know? So it's not just we're just an interpreter. We have to be strong. We have to be professional in a way that we don't let it get to us, body language, everything.

One of the participants also thanked me for completing this research project by saying “*otherwise we are ignored*” (Sylvia). Not only did participants highlight the fact that interpreting is a complex job and should be taken more seriously, but they also talked about themselves as being ‘necessary’ for therapy and services to go ahead, and how this is underestimated:

Francis: Without me they can't do their job.

Such conversations were interpreted as communicating a real need to feel valued and trusted in therapy, with many describing the importance of receiving acknowledgement and positive feedback. Some participants also mentioned the importance of feeling included in the ‘therapy team’ or the overall organisation:

Andrea: there was no need to say anything. I felt it was all understood and it was also the therapist's last session... so we all hugged each other afterwards in the reception... It's like part of being a family who cares for each other.

Helena: I would prefer that the support came from the organisations we work in, that interpreters were valued and the job was understood to a point where they would set up something for us to really include us.

An increased sense of value and appreciation would add to the reported sense of purpose and growth participants gain from their work, which is discussed next.

3.4.4. Purpose and Growth

This last subtheme of 'Current Context vs Aspiration' includes the reflections participants made on what this profession positively contributes to their lives, the purpose and growth it has brought them and how they hoped to continue to develop. With a minority sharing that they came to the profession for more practical perks (e.g. flexibility), the majority of the participants shared that the main reason they continue to work as interpreters was the sense of purpose and "honour" (Sylvia) they gained from working with vulnerable people and facilitating their access to services:

Anna: you look at all the people that are involved in this kind of work, they're all doing it because they care, they're interested in making a difference to the most vulnerable.

Many reported the sense of purpose and growth they gain through the identification with the client in sessions, when the client's mood positively changed or when they recounted a happy ending:

Andrea: So when you are released from prison, how did it feel? And then as if he is released from prison today, although it happened five years ago, this room becomes like American cartoons, flowers, and then Santa. So that's beautiful, and we all feel as if the same thing happening to all of us.

Some mentioned how their work can help them feel "grateful" about their current circumstances:

Sylvia: it just makes myself feel I am so lucky, that whatever I have been through is nothing compared to what they have been through, makes me even more humble.

All participants mentioned appreciating how the variety of the work leads them to develop personally:

Amy: For my interpreting career, I have actually gained a lot of knowledge about different areas to law to education to health service. It's amazing. I can really relate to any area... the other day, one therapist here, she's going to be doing some meditating [with] the client... I will gain something as well.

3.5. Reflections on Data Congruence and Incongruence

As outlined above, the data analysed were heterogenous and participants appear to have adopted different stances in the ways they approach their work in therapy. As previously described, one of the ways these differences were displayed in the analysis was by introducing bipolar themes accounting for multiple perspectives within a certain theme.

Three participants took a particularly different stance compared to the rest of the sample. Amy, George and Beatrice's accounts suggest a more detached and solely linguistic approach to their work (displayed in the themes: 'Just the Words vs Going Beyond'; 'Emotionally Connected vs Detached' and 'Being Strong/Switching off to Survive'). They consider this stance as preventing them from feeling emotionally affected by the work, which makes them less represented in themes concerning emotional consequences (i.e. "It Wears You Down" and 'Sharing Humanity'). Because of how prevalent such themes were in the other participants' accounts, and because of these themes' relevance to our research question on experiences of support needs, these remain central, nevertheless.

While the emotional effects of the work were not deemed to be an issue for George and Amy, they did report frustration at the professional and financial challenges of the profession (theme 'Precarity and the Profession'). Beatrice did not report being affected by her own work conditions, finding her changeable schedule a source of "freedom". However, this theme remains relevant as she did acknowledge how these would be a challenge for other interpreters in other circumstances (e.g. if interpreting is their only source of income, family circumstances).

Overall, Beatrice appeared to be a particularly deviant case in some of the themes identified so explicit attempts have been made to ensure her accounts were not overly marginalised in the analytic process. A careful deviant case analysis was undertaken to "refine the hypothesis until it accounted for all known cases without exception" (Lincoln & Guba, 1985, p.309).

While the rest of the sample advocated for more support (be it training, supervision or better working conditions), Beatrice was the only participant that reported not needing any further support and not being affected by the

emotional or practical challenges of interpreting. This was accounted for in the theme around support needing to be “personalised” and specific to the individual as other interpreters might not feel like they need professional support and, as Beatrice, may prefer to rely on personal strategies and support networks. Beatrice’s strong personal coping strategies were important in our conversation and are included in the theme ‘Maintaining the Balance’. Beatrice’s voice is also very central in the theme ‘Purpose and Growth’ as she considered the work as giving her a lot of freedom and to be a great source of learning across settings. While taking a less emotionally invested approach, she overall came across as enthusiastic about the ways interpreting positively contributed to her lifestyle.

The reasons why Beatrice’s account differed from a central trend in the data may be many. Interpreting being mostly a freelancing career would naturally lead interpreters’ day-to-day experience of the work to vary (e.g. in terms of workload, schedule and/or setting). For example, Beatrice had more experience in a legal setting compared to therapy, which are likely to require increased impartiality and a less emotionally involved stance. The make-up of the work would also be influenced by their working language and organisations’ demand for it. Finally, the sample for this study was very heterogenous in personal factors such as gender, age, and cultural understandings which would all inevitably influence participants’ experience of the work and their perceived support needs.

3.6. Summary of Results

From the analysis outlined above, interpreters working in therapy with RAS appear to report both positive and negative experiences as a consequence of their work. There is a sense of ambiguity around their role in therapy. While a minority tends to focus solely on language interpretation, some feel drawn to do more. All agree that communicating complex language, and bridging cultural boundaries are within their realm of responsibility. Interpreters appear to be more than just observers of therapy and all agree that being trusted by clients and therapists is paramount to their work.

The work is perceived as being emotionally draining in the long run and requiring the development of strong personal coping strategies, due to a lack of professional systems. Interpreting in therapy using the first person, often leads to vicarious participation in clients' traumatic stories. When emotions are triggered, there is a conflict both between and within participants' accounts that describe alternately pushing emotions away as a survival strategy, but also acknowledging the importance of being able to embody the emotions for quality interpreting.

Support systems for participants appear to be largely absent and the limited services historically offered were considered neither safe nor adequate. Participants view useful support as being flexible and allowing for the different work approaches and schedules of interpreters (group, individual reflective spaces, and training). The lack of support systems was often seen to be a reflection of interpreters' being considered unimportant; and improving services to be a message of inclusion and value.

The work of interpreters is precarious, poorly regulated and most participants report poor pay and struggles to gain basic workers' rights as having the greatest impact on their day-to-day life. They describe an urgent need for better organisational structures such as a regulatory body to advocate for better working conditions and ensure protection of title.

Despite these challenges, most interpreters report finding purpose and growth in their work. How these findings are placed within the broader literature and their clinical implications will be discussed in the next chapter.

4. DISCUSSION

This research sought to explore the experiences of interpreters working in therapy with RAS and their support needs. This chapter will discuss how identified themes are placed within the broader literature, and the limitations, clinical, policy and research implications of the study.

4.1. Discussion of Main Findings

The discussion will be organised into sections reflecting the main emergent themes (Emotionally Connected vs Detached; What is my Role?; Current Context vs Aspiration): findings on emotional engagement, the role of interpreters in therapy and organisational structures in the interpreting profession.

4.1.1. Emotional engagement and internal conflict

The participants in this study reported feeling negatively as well as positively affected by their work. This is consistent with the existing literature on interpreters working more broadly in therapeutic settings, outlined in chapter one (e.g. Doherty et al., 2010; Kindermann et al., 2017; Mehus & Becher, 2016; Miller et al., 2005; Shlesinger, 2008; Splevins et al., 2010). The theme 'emotionally connected vs detached' describes the presence of two conflicting positions concerning participants' emotional involvement with the work, with some participants adopting one stance exclusively, and others alternating between stances based on context. Similar to Miller and colleagues' (2005) findings, participants' chosen approach or 'mode' of interpreting appeared to influence where they positioned themselves on this matter (see 'modes' summarised in section 1.3.4.).

A minority of participants seemed to apply a more detached approach to their work ('linguistic mode'), focusing exclusively on cognitive and verbal processing. They believed this improved accuracy and prevented the material 'sinking in'. Conversely, a majority considered being emotionally present and empathic with clients unavoidable and pivotal to achieving 'quality' interpreting

and gaining clients' trust. For these participants, using first person interpretation and personally relating to the trauma, appeared to bring emotional 'identification' with the client, as discussed in earlier studies (Dhinse, 2017; Miller et al., 2005; Splevins et al., 2010; Shakespeare, 2012). Though potentially painful, such identification was seen as bringing personal growth and higher perceived interpreting quality, through appropriately mirroring one's emotional experience ('psychotherapeutic mode').

Themes around emotional engagement with clients and feeling drained by interpreting work occurred in participants' accounts. Some participants described empathy as both exacerbating painful identification and aiding personal growth. These reports are in line with findings reported by Splevins and colleagues (2010) in their qualitative study on VPTG among interpreters. It is possible that there is a relationship between these factors. While previous findings are mixed, the association between empathic engagement and emotional impact is not new to the literature on helping professions. For example, Salston and Figley (2003) consider empathic engagement a risk factor for the development of ST in helpers. On the other hand, Salihovic (2008) discounted the role of empathy in CF in interpreters, arguing lack of support was a greater predictor of CF.

Reflecting findings elsewhere in the literature (e.g. Yick & Daines, 2017) all participants but one described relying on 'detachment' during sessions and/or 'distancing' afterwards to cope. While for a minority detachment was a consistent approach, participants who valued connection with the client in the room described distancing (or 'switching off') happening after the session in an attempt to 'survive' the emotional experience. Nevertheless, most participants described "wondering about the client" between sessions, and still thinking about painful client encounters from years earlier.

Similar to other studies (Yick & Daines, 2017), participants appeared to have developed personal coping strategies to aid such 'switching off' after sessions and 'maintain balance' between their personal and professional lives including physical activity and social contact. In line with previous literature on interpreters (Kindermann et al., 2017; Lai, 2015; Salihovic, 2008) and mental health in general (Harandi, Taghinasab, & Nayeri, 2017), participants' support

networks were crucial and protective, allowing for distraction and 'unwinding' after stressful sessions. However, participants reported not being able to talk about work with their support network for fear of breaching confidentiality guidance, which appeared to be approached with absoluteness.

Most deemed interpreting therapy with RAS to be the most emotionally demanding work and avoided being overwhelmed by pacing the work and spreading it across settings when possible (Doherty et al., 2010). The use of this strategy is consistent with quantitative findings of a correlation between amount of exposure to traumatic material and psychological impact (Salihovic, 2008; Shlesinger, 2006). Participants who were less concerned with the emotional impact of their work reported being 'naturally' able to switch off and being more focused on their personal life than work. As found by Kindermann et al. (2017) it is possible that some personal factors (e.g. attachment style) may mediate the emotional experience of interpreting.

While most participants could recall at least one episode when they became upset during a session, and felt that adjusting to therapy work became easier with time, they also emphasised the longer-term effects of a profession that silently 'wears you down' emotionally and slowly changes your world view into a more cynical and anxious one.

Such reports appear to differ from previous studies (Dhinse, 2017; Miller et al., 2005; Roberts, 2015). Miller et al.'s (2005) participants described experiencing distress during or after sessions mostly at the beginning of their career, but that this was short lived. The study did not specify the amount of experience their participants had, but the mean age of participants was significantly lower (36) compared to our sample (56), possibly indicating less professional and/or life experience. It is possible that younger/less experienced interpreters feel more intense reactions and, with experience, develop coping strategies which help to manage short-term distress. However, prolonged exposure may shape more subtle and pervasive emotional changes. While this construct was not used in this research, the themes of feeling "drained" and generally more negative because of their work, resonate with the conceptualisation of 'occupational burnout' (World Health Organisation, 2018), which Shlesinger (2006) found to positively correlate with interpreters' professional experience. Ultimately, the

results highlighted a tendency to seek detachment and distraction to cope, but psychological theories from a variety of schools of thoughts regard cognitive and emotional avoidance as being only a *short-term* solution to psychological pain (Beck, 1976; Lemma, 2016).

Adding to previous literature on interpreters in therapeutic settings (Gallagher et al., 2017; Yick & Daines, 2017; Molle, 2012), participants appear to be stuck in a dilemma wherein emotional engagement and empathy are valued by therapists and deemed crucial to performing their work well, but the emotions triggered are seen as ‘unacceptable’ ‘dangerous’, ‘unprofessional’ and a sign of weakness. This quandary appears to generate internal emotional conflict. While a minority of participants seem to attempt to ‘solve’ the conflict by avoiding emotional connections completely, others seemed to persevere in offering emotional engagement and tolerating such conflict. While it is not possible to draw conclusions based on this study alone, it is possible that interpreters go on to experience longer-term emotional changes as a consequence of such friction.

Notably no participant recalled therapists criticising them for becoming ‘emotional’ in sessions, rather these narratives appeared to be internalised and implicit. Bontempo and Malcom (2011, p.109) argued that historical narratives and current codes of ethics around ‘impartiality’ “de-humanised” the profession, influenced a gross misconception of interpreters as ‘unemotional’ and ‘machine-like’, and therefore stigmatised very normal reactions to hearing and communicating traumatic material. Societal and service narratives around helping professionals being ‘heroic’ and emotionally unimpacted would also inevitably play a role, as even therapists have felt embarrassed and discriminated against for their own mental distress (Olson, 2002; Zerubavel & O’Dougherty Wright, 2012).

Participants also reported learning and growth from their work, supporting previous findings on interpreters (Gomez, 2012; Splevins et al., 2010) and refugee workers generally (Barrington & Shakespeare-Finch, 2013). Many describe the wealth of experiences and learning gained from professionals across settings and most participants report choosing the profession wanting to help others. They gained satisfaction from supporting vulnerable people and

while doing so became more grateful for their current circumstances. Empathic identification with the client, alongside exacerbating difficult feelings, was also described as intensifying personal growth and appreciation in a sense of shared humanity (Splevins et al., 2010). This finding could support the case for a more emotionally connected, relational style of interpreting in therapy (Tribe, 1998). However, these positive effects may be obscured by painful feelings, if support spaces in which to process these are not offered, as will be discussed in section 4.4.

Since only two interpreters either identified as a refugee or migrated from a country experiencing war, it is hard to comment on the specific experience of refugee interpreters. While both participants reported finding it hard to hear what was happening in their country through clients (as seen in Holmgren, Søndergaard, & Eiklit, 2003), a shared background was mostly deemed to bring connection and a sense of faith that the client would eventually recover. Mehus & Becher (2016) argued that identification may lead to increased growth in this group, which may protect them from work-related distress.

This study challenges other studies reporting overriding poor work satisfaction in refugee interpreters, with Salihovic (2008) hypothesising that this group might be more inclined to choose the profession out of necessity, rather than interest. While most participants (of Western origin or not) shared how they entered the career by circumstance, migrant participants appeared passionate and engaged with their work. This study's results further indicate that hiring interpreters with personal migration stories, provided that they are supported appropriately, would likely lead to more benefits (e.g. engagement and cultural 'bridging') than losses (Miller et al., 2005).

4.1.2. The Complex Role of Interpreting in Therapy with Refugees

While understanding the role of interpreters in therapy was not a core research aim nor prompted by interview questions, the complexity and ambiguity of the role permeated the interviews and clearly played an important role in participants' experience of their profession. As described previously, participants appeared to lean towards different 'modes' of interpreting, with different views on what was within their remit (Gallager et al., 2017; Miller et al., 2005). Overall, this study's findings indicate that for the participants interpreting

involves a lot more than being language conduits and silent observers of therapy and suggests a more relational conceptualisation (Tribe & Thompson, 2009a).

Most participants described the importance of being “human” and empathic, embodying emotions to help convey meaning, fitting with a more ‘therapeutic mode’ of interpreting (Tribe & Thompson, 2017). This group consciously took on extra tasks at times, sometimes actively offering help to foster a safe space, while at other times feeling ‘cornered’ to do this, knowing that no one else would (e.g. walking an anxious client to the session). Interpreters in other studies have mentioned the perceived friction between the high needs of RAS and services’ inability to meet these (Dubus, 2015).

While most participants disapproved of interpreters who were ‘too detached and cold’, they also discussed how ‘doing too much’ and ‘going beyond the boundaries of the role’ may be problematic. This fits with findings by Mirdal et al. (2012) indicating that interpreters considered both under-involvement and over-involvement of interpreters as hindering factors in therapy. A minority of participants took on a more ‘linguistic’ mode of interpreting, stating that they focused solely on language accuracy and cognitive processing. However, as interviews progressed, they often described other roles they inadvertently took on (e.g. providing cultural input).

This study builds on the very limited literature on the experiences of interpreters in therapy with RAS (Gallagher et al., 2017; Miller et al., 2005), further highlighting how this setting appears to present specific challenges such as interpreting psychological terminology, accommodating for clients’ emotional states (e.g. not wanting to talk or crying), the extended concentration it requires and the emotive content of the session. As discussed by Tribe & Morissey (2004), psychological constructs are culturally bound and may not have direct translation in certain languages, and it is not uncommon for interpreters to find themselves in unfamiliar lexical territory (Yick & Daines, 2017). Moreover, while interpreting traumatic material may be required in other settings, therapy involves a more in-depth exploration of such events and relatively longer exposure (Holmgren et al., 2003). This is especially the case of CBT for PTSD,

the recommended NICE (2018) treatment, in which the ‘reliving’ component requires repeating traumatic stories in detail.

As noted elsewhere in the literature (Miller et al., 2005; Tribe & Morrissey, 2003), interpreters act as ‘cultural brokers’ in therapy, bridging gaps in cultural meaning between refugee clients and therapists. Interestingly, all participants considered this to be within the boundaries of their roles. Interpreters leaning towards ‘linguistic’ modes, saw this as necessary for therapists to fully understand what clients were communicating, while those adopting a more ‘therapeutic approach’ added more in-depth cultural brokerage such as alerting therapists to commonly stigmatised issues within communities. This finding might indicate an increased acceptance of the importance of cultural brokering within the interpreting profession. Participants also mentioned facilitating engagement in therapy numerous times, particularly for clients from cultures where therapy is not commonplace, or given in an alternative cultural format (Ross, 2014; Tribe & Morrissey, 2003).

All participants considered gaining clients’ trust to be challenging and pivotal for successful therapy outcomes, as previously found in literature (Gallagher et al., 2017; Mirdal et al., 2012; Miller et al., 2005; Gartley & Due, 2017; Doherty et al., 2010). Reports of clients fearing interpreters’ alignments with abusive governments (Patel, 2002) or breaching confidentiality, especially when the nature of the trauma discussed is stigmatised within their communities (Pugh & Vetere, 2009; Robertson, 2014) were frequent.

Participants’ juggling of the client relationship seemed potentially influenced by cultural aspects, with some cultures finding this harder than others. These observations echoed Green and colleagues’ (2012) study, during which Kurdish interpreters described having to manage a tension between their professional (British) and personal (Kurdish) selves.

Not only do these results highlight how interpreters do not strictly prefer one ‘mode’ over another, but also that they are constantly juggling their roles (Shakespeare, 2012). Participants echoed arguments by Bontempo and Malcom (2012), discussing how the expected “complete impartiality of attitude, speech and script” (DPSI, 2017, p.3) appeared much harder to follow in therapeutic settings, describing one’s “humanity” as naturally leading them to

“empathise” and “feeling drawn” to “advocate” for their client (Participant 10, Francis). It also appeared to leave some interpreters sitting with a sense of helplessness when feeling that they cannot contribute to the interaction, especially when thinking something has been missed in their clients’ care (Shakespeare, 2012).

Therapeutic stances and services may also be guilty of sending double messages, asking interpreters to offer ‘neutral and literal’ translation, but also being an empathic presence, fostering engagement to help bridge cultures (Gallager et al., 2017). Such ambiguity may lead some interpreters to choose one approach across all settings. For example, some participants appeared to be applying models of interpreting perhaps more suited to a legal setting (e.g. narratives around suspending judgement on the validity of one’s torture story). More clarity is needed on how interpreters should approach therapy, as an overly detached or involved attitude may impact on interpreters and clients and potentially hinder therapeutic outcomes.

4.1.3. Organisational Structures Around Interpreters

This section includes findings related to organisational structures, such as participants’ experience of occupational standards and preferred support systems.

4.1.3.1. A precarious profession

When asked whether the profession had an impact on their personal life, most participants discussed the state of occupational standards as having the greatest influence. This can be understood using Maslow’s (1943) ‘hierarchy of needs’, which highlights how certain psychological necessities naturally lose priority when more urgent biological and safety needs are threatened, for example by unstable employment and poor wages. Therefore, such issues cannot be ignored if wanting to foster safety and wellbeing in the interpreting profession.

This study shows that participants perceived interpreting in Britain as an exhausting, underestimated and extremely precarious job. They described a profession in decline, both in terms of quality and stability of employment. Influencing factors mentioned were technological advances gradually replacing

face-to-face interpreting, the lack of a protected title, and the British political climate favouring stricter immigration policies and neglecting issues of equal access to care.

Participants described unpredictable workloads, complete lack of occupational benefits and “peanuts” pay. Even though some participants classed certain issues (e.g. lack of sick or annual leave) as natural ‘trade-ins’ when taking on a freelance career, it appeared that more stable employment is not an option for interpreters anymore, as organisations now largely rely on agencies. With agencies naturally taking a percentage, the discrepancy between requisite competencies and pay further increases, as appropriately summarised in Gallagher et al. (2017 p.340)’s metaphor “being paid to be a machine for a human role”.

In line with the literature on the negative impact of precarious employment on mental health (Canivet et al., 2017), working conditions naturally appear to trigger significant anxiety for most participants and affect their sense of self-worth. These reports differ from Baistow’s (2000, as cited in Valero-Garcés, 2005) finding that interpreters in Britain were more concerned with isolation than working conditions. While differences in sample size makes comparison hard, the contrast may be suggestive of work conditions deteriorating over the last twenty years, as some participants highlighted.

Interpreters appear to wander through the professional space unanchored, creating working relationships where they can but not having a consistent supporting organisation to rely on. An overarching body or union was deemed important to regulate and represent interpreters’ voices in political spaces and contribute to the betterment of interpreters’ work conditions and the quality of interpreting services offered nationally. There was also a sense that such an organisation may serve participants’ unmet emotional needs. As argued by Blackwood, Lafferty, Duck & Terry (2003, p. 285) belonging to a union/professional body is an “affective experience”, providing a sense of attachment and solidarity.

As will be discussed, appropriate support for interpreters is absent. Lack of professional representation may be a contributing factor as to why better systems are yet to be developed.

4.1.3.2. Support

This research adds to the previous literature describing inadequate support available for interpreters (e.g. Miller et al., 2005). However, similarly to the literature on work standards, international variance in organisational structures may make it hard to compare findings.

No participants were aware of any resource available, if they were to need emotional support after a session. A minority, mostly those who had worked with the charity for a long time, stated they would go to a trusted therapist at the recruitment charity (Doherty et al., 2010). The large majority said they would continue with their current personal strategies and, if they became very distressed, would see their general practitioner or self-fund counselling services. One interpreter said they would leave this line of work completely.

These accounts appear to mirror results of Lai and colleagues' (2015) survey, in which interpreters showed reticence to seek support, despite reporting heightened distress. The overall impression was that emotional support in the workplace is not an option for interpreters and that help should be sought only once requiring clinical treatment in health services. Not only does this indicate a tendency to exile emotional experience from the workplace, but it encourages a very reactive (rather than proactive) approach to occupational stress, which is likely to exacerbate distress and increase pressure on stretched public mental health services (Harper, 2016).

McCann and Pearlman (1990) argued that a supervision is crucial to process and normalise feelings and dilemmas triggered in interpretation sessions. Such experiences are not uncommon in other helping professions, such as psychologists, but they appear better equipped with spaces to safely process such conflicts (Fleming & Steen, 2004), instead of pushing away difficult emotional experiences, which may then return as more serious mental health concerns.

All participants appreciated being offered briefings and debriefings, but these rarely happened (as seen in Miller, 2005). This is concerning, given literature has identified that lacking these spaces makes interpreters' job more challenging (Doherty et al., 2010), and shows non-compliance with professional

guidelines (BPS, 2017). Current participants described the importance of 'being held in mind' by clinicians and their emotions being acknowledged, with the explicit option to talk, might prevent their need for further support.

Participants report that some providers had attempted to offer support spaces before, but they had been considered inadequate, due to requiring interpreters to pay, being inconvenient in time and location, or temporary. Most participants acknowledged that financial struggles encountered by the charities they work for is a barrier to offering support, as also found in the survey by Dergam & Valero-Garcés (2001). Some support resources had not felt emotionally safe, which was deemed to be important, especially given many participants felt shame about needing support and worried about their vulnerability being 'exposed'.

Participants had different views on what support should entail, but all argued against a 'one size fits all' approach due to interpreters being heterogenous in lifestyle, caseload mix, and interpreting approach. While the participants with a more 'linguistic' approach were more interested in training, interpreters taking a more emotionally involved stance strongly argued for supervision spaces to be offered, with one participant even stating this should be compulsory to attend.

Most participants conceptualised supervision as a group space for reflection with other interpreters, with some also suggesting training alongside open discussions (Sande, 1998). Most thought individual sessions with therapists should be offered to those who may find groups hard to attend emotionally or practically. All thought groups should be facilitated by an 'expert' in therapy interpreting, either an interpreter or a clinician or both, providing input around technical skills and self-care strategies.

Most thought support services should be offered by the providers rather than agencies. Not only did most participants feel a stronger sense of belonging towards these organisations, but they also thought supervision should be specific to the services each organisation provides. Some did not think providing support to interpreters would be within the charity's responsibilities, but they could not think of an alternative.

Several participants commented that offering such spaces would implicitly send a message of inclusion, potentially contributing to shifting organisational culture, as was found in the supervision group described by Tribe (1998). The current study, alongside others (Shakespeare, 2012), highlights how interpreters perceive themselves as undervalued and “no one’s priority”. Most participants were explicit about valuing inclusion and belonging in therapeutic spaces and mentioned feeling part of a “team” or a “family” with clinicians, supporting the conceptualisation of interpreters as active members of a therapeutic ‘triad’ (Miller et al., 2005). Interpreting is a lonely job and peer-support might increase a sense of belonging and buffer against psychological distress (Solomon, 2004).

Most highlighted the need for further training specific to therapy skills. Participants described feeling disoriented at times, not understanding the context or techniques applied in the therapist-client interaction and felt this negatively impacted their interpretations, and perhaps to perceived lack competency and control (Molle, 2012). Doherty and colleagues’ (2010) survey indicated counselling skills training reduced the negative impact of interpretative work.

As mentioned, confidentiality appeared to be applied rigidly by participants, and triggered significant anxiety, with some even extending rules to not feeling or thinking about what discussed in sessions. I wondered whether confidentiality may also be used as a psychological defence, for participants to protect themselves from processing trauma material (Lemma, 2016). Such processes could be reflected upon in supervision spaces and interpreters may go on to develop more flexible approaches while respecting clients’ confidence.

Furthermore, while specific literature was not found, one individual account (interestingly, shared by one of the participants via email) argued that the profession’s relationship with confidentiality is a barrier to interpreters accessing support. They suggested adding a caveat to their code of conduct to make certain allowances (e.g. discussing anonymised material) more explicit (Inside Interpreting, 2020). These are commonly used and formally acknowledged in the therapy field (e.g. Association of Child Psychotherapists, 2017).

Finally, I noticed that participants with longer experience in British mental health settings, most of whom were of White European backgrounds, tended to bring forward the concept of ‘supervision’, while participants with less experience, mostly from BAME backgrounds used more general terms (“groups”, “teaching”). It is crucial to hold in mind that supervision is a Western approach to organisational support, and that it might be a confusing and stressful space for novice, non-western interpreters (Sande, 1998), especially since the label echoes narratives of management and monitoring. In this multicultural professional group, it is important that support structures “model openness” to issues of “cultural difference and racial oppression spanning the personal, professional and theoretical realms” (Patel, 2004, p.116).

4.2. Implications of This Research

This research has a variety of implications for research, clinical practice and broader societal structures.

4.2.1. Research Implications

This study highlighted the perceived lack of clarity around role parameters for interpreters in therapy with RAS. While some research is available on interpreters and clinicians’ position on the matter, the clients’ perspective is largely absent, as well as evidence on which approach leads to better therapeutic outcomes. More research studies looking quantitatively and qualitatively at clients’ experience of therapy through an interpreter are very much needed, to make firmer conclusions on which skills are required (and how they differ from other settings), in order to inform training, support and recruitment. Furthermore, the literature indicates that empathic ability may be important, but that it may also lead to increased work-related distress. Larger size studies would be useful in clarifying how generalisable this correlation is and how this should inform support structures.

Regarding research on support, while quantitative research may be useful, the literature shows that the population of interpreters is extremely heterogenous. Larger samples may be helpful in terms of generalisation, but they might lack sensitivity to individual, local variation. The current results suggest advocating

for localised investigations, whereby specific organisations can consult their interpreters on how to best meet their needs. In a larger, more populated area like London, requiring a higher number of interpreters (NRPSI, 2019a), organisations could undertake joint service development projects and perhaps join forces in creating better support for the interpreters they simultaneously employ.

Furthermore, as mentioned in the first chapter, the majority of studies exploring interpreter-mediated psychological therapy, have been undertaken by mental health professionals. This is not surprising, since the aforementioned occupational challenges would create barriers to interpreters engaging in research. Equipping interpreters with skills and resources for research or opting for Participatory Action Research (PAR; Bergold & Thomas, 2012) approaches could ensure the involvement of interpreters and may lead to more practical changes in the profession, such as informing new occupational policies.

4.2.2. Clinical Implications

This study has clinical implications for work with interpreters. It contributes to a growing body of evidence showing that most interpreters, and therapists perceive themselves as belonging to a 'triad,' where interpreters play a greater role than passive observers of therapy. Alongside the very complex role of language interpretation, they are pivotal bridges of therapeutic engagement and cultural meaning. More acknowledgement of these functions is urgently needed, as this research has highlighted how misunderstanding and underplaying this role can be a challenge for interpreters. The 'interpreter' label may arguably not be appropriate for therapeutic settings anymore, and titles such as 'cultural mediator', commonly utilised in other countries, might be more comprehensive and clearer (Andolfi, 2003; Mendoza Berjano, Gualda, Spinatsch, & Markus, 2019).

The guidance on what falls within the remit of interpreters in therapy is vague, creating ambiguity and anxiety for interpreters. More explicit communication is needed from clinicians and organisations on what role they prefer interpreters to take, and this should be negotiated in dialogue with interpreters. Avoiding this conversation may lead interpreters to choose emotionally 'neutral' roles they

apply in other settings (e.g. courts), which might not be suitable to therapy and may even hinder the therapeutic alliance.

Since interpreters are taking on such complex relational roles, they naturally encounter emotional challenges and professional dilemmas. Therefore, it is crucial that support systems are available to reflect upon these to protect interpreters' and clients' well-being. For organisations and clinicians to ask interpreters to take on more relational roles without due support, is ethically dubious.

Interpreters currently feel uncomfortable and embarrassed about displaying emotion in the workplace, and cope with their emotional experiences by detaching and 'switching off'. As discussed, this may lead to greater distress in the long term, with interpreters requiring clinical input or leaving the profession (Lai et al., 2015). Better support structures would normalise such experiences and allow interpreters to process their emotional reactions in more helpful ways. Since previous structures are reported to not have reflected interpreters' needs, paid, interpreter-led consultation should be sought in designing these resources to ensure they meet interpreters' needs, such as being appropriate in location, timing and payment (Ryan & Bamber, 2002).

This research has shown that organisations interpreters work for (and not agencies), were deemed by participants to be best placed to offer these services. Patel (2019) reminds us that the ethical obligation of 'do no harm' that these organisations have towards refugee people, also applies to the professionals supporting them. Community organisations should be granted the funding needed to offer such services.

Based on this study's findings, support provided should be specific to therapeutic work but offered in several modalities, to accommodate for the different needs of this heterogenous population. It should include a group component of learning and reflection, facilitated by a clinician or an interpreter experienced in therapy, ideally both. Due to the different approaches that interpreters use, the setting up of such groups should involve conversations on their preferred format (e.g. more reflective or skill-focused) (Tribe, 1998). Individual time with a clinician should be arranged for interpreters who prefer or are unable to join such groups. Training to increase knowledge of therapy and

ways of coping with the consequences of the work was also seen as vital. This would decrease the risk of interpreters feeling confused about what is happening during sessions and potentially aid the quality of their interpretation.

Interpreters highly valued being held in mind. Clinicians should be alert to interpreters' mental states, both during and at the end of the session. Briefings and debriefings should always be available, (Tribe & Thompson, 2017) and these should be explicitly offered by clinicians, since the literature shows that interpreters may find it hard to ask for support. Separate physical spaces for interpreters, if feasible, to prepare and unwind before and after sessions, would also play a role in fostering emotional processing (Tribe, 1998).

4.2.3. Policy and Occupational Implications

Participants have clearly spoken throughout this research on the need for better representation and regulation of the interpreting profession. While only mentioned by one participant, NRPSI (2019b) shared that their 2019-2021 strategy will focus on increasing membership and lobbying government for protection of the interpreting title. The power of professional bodies to monitor the quality of interpreting is limited until this is achieved. As long as any untrained person can work as an interpreter, especially in an austerity climate prioritising cost over quality of care, standards and job protection will suffer.

It is important that health organisations be allies of NRPSI in achieving these goals. While not currently possible for organisations to *solely* rely on the NRPSI due to some languages being poorly served, organisations can implement policies stating that registered interpreters be given preference. This would serve the double purpose of increasing quality by ensuring that employed interpreters hold an interpreting qualification whenever possible as well as increasing the bargaining power of this resource. Increasing protections would likely mean higher pay for trained interpreters and a greater acknowledgement of the role they play in our multicultural society.

Mental health organisations should also work closely with the register to develop appropriate continuous professional development on working in therapy. This would ultimately streamline many in-house trainings, better allocating resources. Such trainings should include as a minimum self-care,

counselling skills and allow for appropriate conversations around confidentiality. In the long term, NRPSI and the Institute of Linguists, responsible for the DPSI qualifications, could join forces to develop an appropriate professional specialisation in mental health for those wanting to specialise in this field.

Attempts should be made by organisations to hire interpreters on more stable contracts especially in organisations serving specific communities and requiring certain languages more frequently. One of the participants highlighted hiring interpreters as bilingual community workers offering more services than language interpretation to be a potentially productive allocation of resources. Cancellation policies should be fairer in therapeutic work, where a long-term commitment is often expected of the interpreter but with limited protection against last minute cancellations. Hiring interpreter coordinators for services requiring their employment regularly, would ensure sustained efforts are made to improve their work experience. This is particularly important now, in the midst of a global pandemic, as outlined in the next section.

4.2.4. Interpreting during and after Covid-19.

The advent of a pandemic emergency has made starker how certain professions live in precarious balance, which can easily be disrupted by broader societal events. Most if not all interpreting work has moved remotely, and many bookings will have been cancelled due to reduced engagement in therapy. Alongside the impact on clients' access to health services, reduced hours mean lower incomes for interpreters who are also unlikely to receive sick pay, were they to fall ill (Goldberg, 2020; Galvin, 2020).

For those who continue to work, they do so with even less support links, at a time when they would need it most. Working from home poses physical (e.g. having the space to complete jobs), technical (Dubus, 2015), and psychological challenges (e.g. work-life balance, increased worry about confidentiality). Clinicians continue to keep interpreters in mind, offering remoted briefings, training and supervision.

Furthermore, the lockdown is likely to have a large economic impact and therefore public and community services will likely face urgent issues around ongoing survival and interpreters' occupational struggles may again fall to the

'bottom of the list' (Weakley, 2020). Psychologists should act as allies of community organisations and interpreters, by lending their expertise in providing evidence of such financial needs as well as pushing for better working conditions for interpreters. The profession is increasingly moving towards acknowledging their power in political spaces (Patel, 2019) and psychological services have leverage in refusing to hire interpreters from, or reporting, agencies who mistreat them.

Finally, it is possible that the sudden move to remote work might mean an increased push to offer services online after this public health crisis. The challenges of offering, interpreting and receiving therapy remotely in refugee work should be kept in mind by all services, to ensure ongoing occupational well-being and equal access to care.

4.3. Critical Evaluation

4.3.1. Novel Contribution to the Literature

This study's findings build upon previous literature on the experiences of interpreters in therapeutic settings, while providing further insight into the specificity of therapy with RAS and adding novel information about interpreters' experiences of support. Unlike many papers in the literature that adopt specific psychological theory and constructs (e.g. VT, CF), this paper attempted to take a more curious and holistic approach, by minimising psychological language and rigid constructs in the interview and analysis process. This was explicitly done to ensure wider accessibility and to avoid the 'mystique' of psychological language, which can often appear an unnecessary barrier to understanding the profession.

There is moderate overlap between this study's results and earlier literature on interpreters' experiences of therapeutic settings. This may be attributable to the fact that therapeutic settings are not easily separable, and it is very likely that studies in community and mental health settings involved a proportion of work in therapy with refugees. Furthermore, there may be generic challenges (e.g. technical and occupational) that arise in therapeutic settings in general, whether or not RAS are involved. Similar to some of those studies, participants reported

distress as well as positive emotional changes as a consequence of their work and brought forward the real ambiguity of this role and the need for further inter-professional clarity and guidance.

While existing literature briefly touches on the issues of occupational standards in the profession (Baistow, 2000, as cited in Valero-Garcés, 2005) or explains it in relation to a very specific group (e.g. Polish interpreters: Gallagher et al., 2017), the current study offers a significantly more in-depth exploration of the perceived challenges of the British occupational framework. Literature from other countries on this matter is of limited use, due to differences in policy and legislation. Since these matters appear so prevalent in our results, it is also possible that these issues were discussed in interviews in other studies but omitted in analysis as peripheral to these studies' research questions. A TA approach to analysing experiences more generally, appears to have allowed space for the emergence of discussions centring systemic issues.

Above all, this study provides particularly novel information in its findings around support, as no study was found on how interpreters experience and conceptualise useful support. It is likely that empirical attempts have been made to seek interpreters' opinion on the matter within the organisations hiring them, but such findings do not appear to be present or easily accessible through academic literature databases. The academic literature found on support is very superficial, or exclusively provides clinicians' accounts on the support offered to interpreters.

This research suggests that support for interpreters is non-existent and that such absence is experienced as a message of interpreters' peripheral position in organisations, when most participants sought increased inclusion instead. The few participants that used support structures in the past, experienced them as unhelpful or unsafe. Lack of compensation, inconvenient location as well as strict or unclear confidentiality rules were perceived challenges to engage in support spaces. Participants deemed being held in mind and being in open communication with clinicians as crucial to feel supported and contained at work.

In terms of specific support structures, this study highlights the importance of offering personalised and varied support to interpreters, as the reported

differences in approaching the work would not allow this group to benefit from just one support format. Overall, participants experienced useful support as increased spaces for reflection and a mix of peer and expert-facilitated learning.

Furthermore, this study builds on previous studies on interpreters' reticence to display emotions at work (Molle, 2012) by highlighting that interpreters may also find it hard to access support in the workplace due to fears of being judged as 'weak' or 'unprofessional'. On the other hand, some participants described times when their feelings had been welcomed by clinicians as "powerful" and "a relief", highlighting the importance of normalising such experiences, especially in a therapy setting. Overall, interpreters appear to be seeking more inclusion and emotional containment from the organisations that employ them.

4.3.2. Rigour

While a more detailed account of quality assurance was provided in Chapter two, a further assessment of this study's rigour is warranted (Spencer & Richie, 2012).

For research to be 'defensible' it must follow a coherent rationale. The rationale for undertaking an in-depth study on the experiences of interpreters working in therapy with RAS was outlined in chapter one, while the reasons behind the methodological choice were discussed in chapter two.

This study's credibility (i.e. plausibility of its findings) was enhanced by including multiple quotes to illustrate the themes and by discussing these in the context of the broader literature earlier in this chapter. Sending a coded transcript and raw data to my supervisor for inter-coder comparison was important to deepen my analysis and ensure themes were coherent and credible (O'Connor & Joffe, 2020).

To increase transparency, I kept an audit trail to monitor each stage of the research, and I shared some of this material in the appendices (L, M, N, O, P, Q). In chapter three the findings of the analysis have been presented with the relevant extracts of raw data.

Finally, attention to reflexivity has been given at each stage of this project. This was aided by conversations with my supervisor, with a peer TA researcher and

through keeping a reflective diary. Personal reflections have been included in chapter one, two and final reflections will be shared later on in this chapter.

4.3.3. Limitations of the current study

This study aimed at an in-depth exploration of interpreters' experiences and did not aim for population-level generalisation of its results. Nevertheless, it is important to mention its small (n=11) and localised sample and to urge caution when applying its findings in other settings or areas.

Furthermore, the self-selecting nature of the sample might have caused a bias towards interpreters with personal interests in the topic, or those who were particularly affected by their work. Conversely, given the working conditions discussed and the fact that face-to-face interviews can be emotionally difficult to engage with, it is also possible that some interpreters experiencing work-related distress felt unable or unwilling to participate. It is important to note that the sample appeared weighted towards interpreters with significant experience. The experience of newer interpreters may be underrepresented in the data.

Even though all participants worked for more than one organisation and despite it being made clear that declining to participate would not impact their employment, it is possible that recruiting through their employer might have had an undue influence on their choice to participate and what they were willing to discuss.

This study's research questions were broad and included both an exploration of experiences in general and more specific experiences of support. It may be that such double purpose blurred the focus of this study. However, exploring general experience first felt important for two reasons. First, to gain a greater understanding of interpreters' accounts of working in therapy with refugees, as limited literature was available in this specific setting. Secondly, initial literature scoping had led me to believe support structures for interpreters were not available, which was then confirmed by my participants. I hypothesised this would make it hard for participants to comment on what support is suitable having had limited opportunities to experience it first-hand. This hypothesis was confirmed by participants at times struggling to bring forward views on their preferred support, relying on other profession's available structures (e.g. clinical

supervision). Exploring personal accounts of the work and its perceived challenges first, helped in funnelling down to what support participants saw as suitable to overcome these within their own professional framework.

However, reflecting on my methodology a posteriori, some of the questions on the interview schedule were quite specific (e.g. around coping and preferred support) and phrased in a survey-like format. While these prompts were not followed strictly and I made sure I was led by the participants in what accounts they deemed most relevant to their experience of interpreting, more open questions on experiences would have been a better fit for the aims, research questions and epistemology of this study. Despite this limitation, I believe this study appropriately answered its aims and research questions and achieved a broad exploration of interpreters' day-to-day experiences of the work in therapy with refugees and of the support needed in this setting.

Finally, the time limitation of this study and the foreseen challenges in reaching interpreters has meant that limited consultation was sought. Having more involvement of interpreters in the initial stages of the research, might have raised sooner the perceived impact of the occupational challenges in the profession and the schedule would have been adjusted to allow more space for these discussions.

4.3.4. Reflection on Role of the Researcher

A CR epistemology calls for the researcher to add a level of interpretation to the data by drawing on relevant theory and personal experience to generate themes. While attempts to foster transparency have been described in chapter one and two, a further acknowledgement of how my assumptions may have influenced the results is needed.

My identity as a mental health professional would have invariably influenced the interview material and the relevance I assigned it. I noticed that most participants referenced me as being a clinician (e.g. "you guys get supervision", meaning psychologists). As discussed in chapter one, clinicians hold a surfeit of power in the therapeutic space, which may have impeded on interpreters speaking openly about their experience. Some participants appeared keen to tell me they solely focused on their role as 'language conduits' but then went on

to describe other tasks they tended to take on. While this might be related to the intrinsic ambivalence of therapy interpreting, it could also have been influenced by participants wanting me, a TCP, to know that they were observing the boundaries of their role and not 'stepping into' the therapeutic space.

Such a tendency was also noticed by Gallagher and colleagues (2017, p. 341), also psychologists, who reported participants appeared to feel "safer" by describing their work as a "solely linguistic exercise". Similarly, participants approach to confidentiality may have been more flexible than described, but they may have felt the need to stress with me that they were following their professional code of conduct.

Moreover, when asked about the impact of the profession, most participants started by telling me about their emotional and psychological experiences, perhaps assuming this is what I would be interested in. Most conversations around occupational standards happened towards the end of the interview, triggered by prompts. My identity as a psychologist may have led them to not bring forward that side of their experience earlier.

Furthermore, participants at times talked to me as if I belonged to the recruitment organisation, even though it was clearly explained that I was external. Participants' relationship with the charity was overall very positive, but it is possible my partnership with the charity might have impacted on their ability to share whether they felt negatively about the work or the support received, due to consciously or unconsciously worrying about their professional relationship.

My ethnic background may also have impacted on interactions and analysis. While I attempted to be curious and open when exploring participants' experiences, more cultural nuances around how the work is perceived might have been missed. Ensuring extracts covered all participants and backgrounds was crucial. However, it is also possible that interpreters from non-Western background did not bring certain cultural aspects forward, due to thinking they were not appropriate to the encounter with a western, White psychologist.

Finally, my knowledge and training in Western psychological approaches would have influenced this research, especially my studies in Italy (strongly grounded

in psychodynamic theory) and my training at UEL (with a focus on Critical Psychology). Psychodynamic teachings lead me to conceptualise a lot of human behaviour in terms of 'defences' people put in place to protect themselves from psychological pain (Lemma, 2016). Consequently, I often felt the impulse of understanding interpreters' denial of work-related distress as a form of defence. I am also aware of my critical views on the passive position psychology has historically had on political matters. Resisting the pull to comment on these topics in interviews and reverting to the material time and time again allowed me to ensure I had appropriately listened to participants accounts and I was not led by my own agenda. Both these perspectives are also probably guilty of not focusing enough attention on expressed positive feelings. A conscious effort was made to ensure participants had the space to talk about how interpreting positively contributes to their lives.

5. CONCLUSIONS

This study has expanded on previous literature by exploring interpreters' experiences of therapy with RAS. Participants described difficult emotional experiences as a consequence of the work, as well as growth and learning. 'Identification' with the client appears to be frequent for some, which is intensified by first person interpretation and personally relating the story told. Participants are found to experience internal conflict between valuing emotional connection and not wanting to show emotion at work due to fearing judgement. Furthermore, the ambiguity around the role of interpreters in therapy can trigger significant anxiety and self-doubt.

No study had hitherto brought forward such an in-depth account of the perceived occupational challenges in the profession, which was seen to be precarious and in decline, as well as affecting participants' sense of safety and self-worth. This is also the first study among those identified that explored interpreters' personal experiences of support. This support is almost completely absent, and when offered, was perceived as unsafe and not well planned. This study's findings indicate that individualised and multi-modality support is urgently needed and that interpreters seek more inclusion and containment.

While this study has limitations on its generalisability, it does provide an in-depth account of the experiences of interpreters working in therapy with RAS in London. As such, some of its findings may be transferable, with appropriate caveats (Leung, 2015).

These findings should be used to inform support for interpreters and to promote the recognition and regulation of the profession. More research is needed to understand which interpreting approach is best suited for therapy with RAS, what clients' views are and what leads to better therapeutic outcomes. Due to the heterogeneity of this group, employers should have internal investigations on how to best support their interpreters. Interpreters should be encouraged and equipped to engage in research, given the dearth of interpreter-led research. If mental health professionals were to approach such topics in the future, PAR approaches might be more suitable, in order to ensure increased

interpreter involvement and co-construction, potentially leading to more significant and positive changes within the profession.

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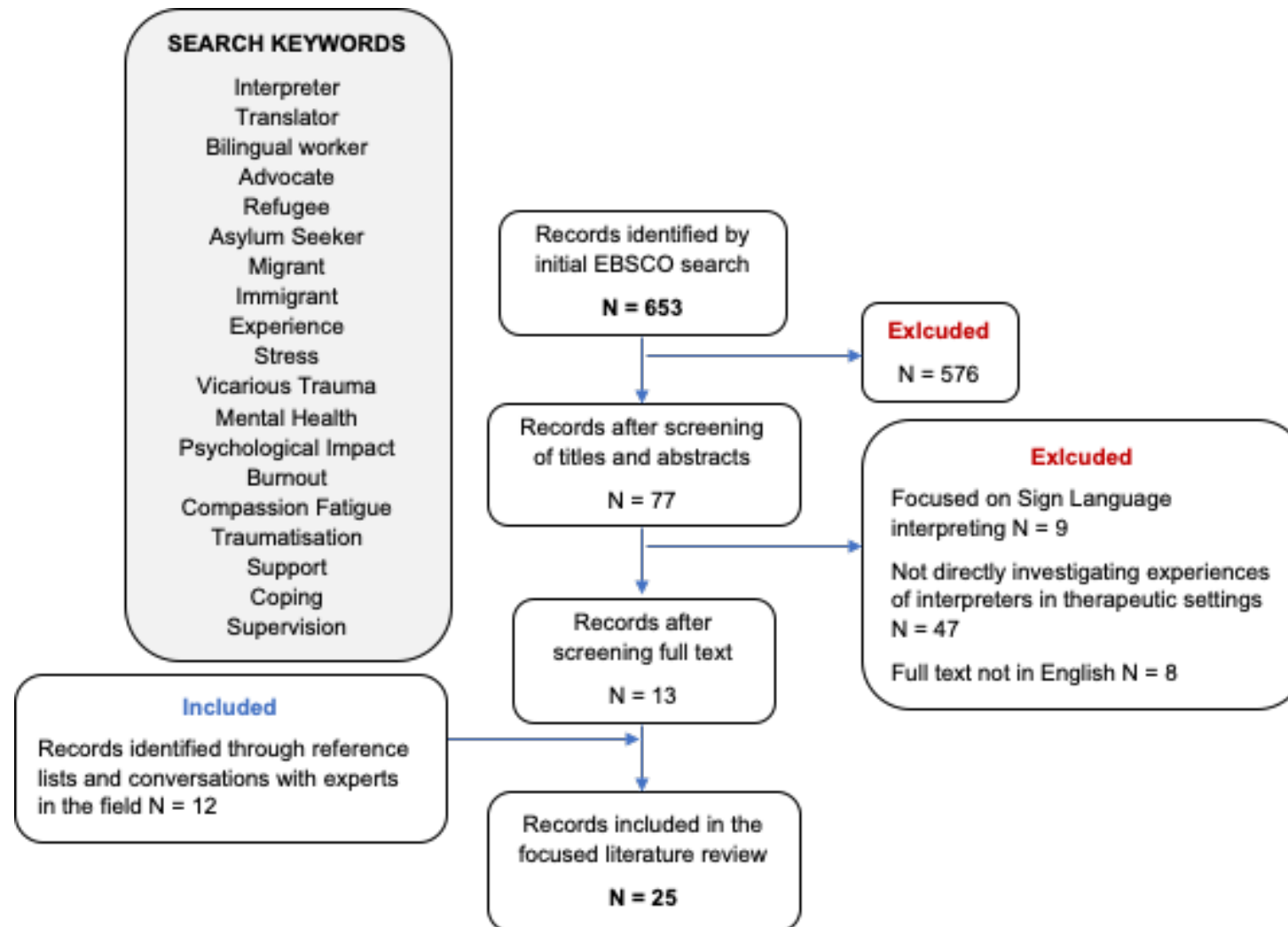
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Appendix A: List of Abbreviations

BPS	British Psychological Society
CBT	Cognitive Behavioural Therapy
CF	Compassion Fatigue
CP	Clinical Psychology
CR	Critical Realism
CS	Compassion Satisfaction
DPSI	Diploma in Public Service Interpreting
HR	Human Rights
NICE	National Institute for health and Care Excellence
NRPSI	National Register of Public Service Interpreting
PAR	Participatory Action Research
PTSD	Post-Traumatic Stress Disorder
RAS	Refugees and Asylum Seekers
ST	Secondary Traumatization
TA	Thematic Analysis
TCP	Trainee Clinical Psychologist
UN	United Nations
UNHCR	United Nations High Commissioner for Refugees
VT	Vicarious Trauma
VPTG	Vicarious Post-Traumatic Growth

Appendix B: Record Search Flow Chart



Appendix C: Interview Schedule

Pre-Interview

- Introductions, Information provided verbally as well as through the Participant Information Letter.
- Do you have any questions?
- Consent Form Signed
- Demographics – gender, age, ethnicity, nationality, language they interpret, if they used mental health services

Interview (Audio-Recorded)

- What's your involvement with the charity? Do you interpret anywhere else?
- How long have you been interpreting for?
- What brought you to this profession?
- What's your personal experience of interpreting in therapy for refugees?
- What do you enjoy about it?
- What are the challenges of this kind of work? (prompts: emotional? Social?)
- How does it affect you?
- Does it have consequences on your day-to-day life?
- How do you manage these consequences?
- Where do you go to for support?
- Where do you not go for support, and why?
- If you could design your ideal support resource, what would that look like? Who would offer it?
- How do you hope things will improve in the interpreting profession?
- Is there anything you would like to add?

Post-Interview

- Thank you for sharing your experience
- Debriefing offered, contacts of support organizations provided (via Debriefing Letter)
- Is there anything you wished I had asked/had been different?

Appendix D: Social Media Consultation Feedback

Post shared on social media

Dear all,

I hope it is okay to post here. I am a trainee clinical psychologist and doctorate student. I am writing to consult you on my research project on the psychological impact interpreting in therapy with refugees has on interpreters. It will be a qualitative study using interviews (around 60 mins long). I hope the results will be useful to improve support systems for interpreters working in this field. I'll attach below the draft of my interview schedule and I would really appreciate feedback from interpreters working in this field to make sure my questions are relevant to this group. Am I missing something? Is any of this more\less relevant?

Any input would be much appreciated.

Thanks a million in advance

Best Wishes

Martina

Response

On line Platform	N. Likes	Comments/Private Messages
Response to post on 4 Facebook groups	10	"good of you"; "thank you"
Response to post on Reddit via private message	N/A	<i>"Hi! I'm not an interpreter but I work in HR with and for interpreters. I see many who leave the profession because of emotional strain. I think what you're working on is very relevant and important and I thank you for bringing it to light!"</i>
Response to post on Facebook via private message	N/A	<i>"Yes, of course I find it important and there should be emotional support for interpreters dealing with such kind of situations. This is my personal opinion but I don't know if many colleagues will agree. Well, I think you've covered all the aspects of the subject, I don't have anything to add I wish you best of luck with your research and the outcomes be fruitful"</i>

Appendix E: Participant Invitation Letter



PARTICIPANT INVITATION LETTER

Dear Participant,

My name is Martina Di Braccio and I am the researcher of the study you are being invited to participate in. Before you agree it is important that you understand what your participation would involve. Please take time to read the following information carefully.

Who am I?

I am a Clinical Psychology Doctorate student in the School of Psychology at the University of East London. As part of my thesis project, I am conducting the research you are being invited to participate in.

What is the research?

I am conducting research into the impact interpreting for refugees in therapy has on interpreters, how they manage the challenges and what their support needs are.

My research has been approved by the School of Psychology Research Ethics Committee. This means that my research follows the standard of research ethics set by the British Psychological Society.

Why have you been asked to participate?

You have been invited to participate in my research as someone who fits the kind of people I am looking for to help me explore my research topic. I am looking to involve **interpreters working in therapy with refugees**.

I emphasise that I am not looking for 'experts' on the topic I am studying. You will not be judged or personally analysed in any way and you will be treated with respect.

You are quite free to decide whether or not to participate and should not feel coerced.

Declining would not have any impact on your relationship with the organisation you work for.

What will your participation involve?

If you agree to participate you will be asked to engage in an interview with me. This will be an informal chat and will take place in a private room, it will last approximately one hour. I will ask you some broad questions to understand more about your experience of interpreting in therapy for refugees. I am interested in hearing your personal experience, so there is no right or wrong answer. The interview will be audio-recorded for me to be able to analyse the interview data.

To thank you for your time and invaluable contribution to this research, **I will offer you a Love2Shop voucher of the value of 10 pounds**.

Your taking part will be safe and confidential

Your privacy and safety will be respected at all times. Your name, contact number and the interview recording will be stored in an encrypted folder in a password protected-computer and no one apart from the researcher will have access to it. The recordings will be transcribed by the researcher themselves. The transcripts will be anonymised by assigning a fictitious name or number and any identifiable information will be omitted from the data. These will only be accessible to the researcher and their supervisor.

You have the right to withdraw or have breaks at any point during the interview and this will have no consequence on your relationship with the organisation you work for. As we will be discussing sensitive topics, you may feel emotional during the interview. Again, you can stop or have breaks if you need to. The researcher will allow time at the end for a debrief and will be able to suggest organisations you can contact if you require further support.

What will happen to the information after the study?

Your name, contact details and the recording of the interview will be securely stored till confirmation of degree then deleted. The anonymised transcriptions will be kept up to 3 years after the study submission to allow for publication of the results. You will be able to withdraw your data until up to the point of analysis by contacting the researcher, if possible within 3 weeks of the interview taking place.

What if you want to withdraw?

You are free to withdraw from the research study at any time without explanation, disadvantage or consequence. However, I would reserve the right to use the interview material if it has already been analysed.

Contact Details

If you would like further information about my research or have any questions or concerns, please do not hesitate to contact me.

Martina Di Braccio (██████████@uel.ac.uk)

DClinPsy Student

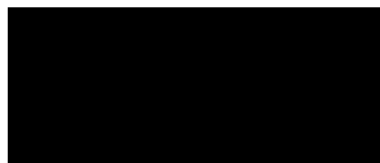
If you have any questions or concerns about how the research has been conducted please contact the research supervisor Dr Nicholas Wood, School of Psychology, University of East London, Water Lane, London E15 4LZ,

Email: ██████████@uel.ac.uk

or

Chair of the School of Psychology Research Ethics Sub-committee: ██████████,
School of Psychology, University of East London, Water Lane, London E15 4LZ.
(Email: t.lomas@uel.ac.uk)

Appendix F: Recruitment Leaflet



DEAR INTERPRETERS, WE WANT TO HEAR FROM YOU!!

I am a UEL Doctorate Student and, with the support of the [REDACTED] I am completing a research project on:

The experience of interpreters working in Psychotherapy with refugees, the challenges of this work and how they would like to be supported.

Your participation would involve an informal interview of about 1 hour which we can arrange according to your schedule either at [REDACTED] or at UEL (Stratford).

Your contribution would be invaluable in informing better support systems for interpreters.

To thank you for your time, I will be offering a £10 Love2Shop Voucher (redeemable at 20000 shops in the UK)

Contact me to participate or for further info:
Martina Di Braccio ([REDACTED]@uel.ac.uk; XXX)

OR leave your details with the [REDACTED] and I will contact you.



Appendix G: Participant Details Sheet

Participant Details Sheet

Name:

Surname:

Gender:

Age:

Ethnicity:

Nationality:

Interpreting Language(s):

Once the data has been analysed, I would like to contact you to share the results with you. Would you like to be contacted?

Yes No

How would you like to be contacted?

Phone Email

Phone Number:

Email Address:

Appendix H: Consent Form



UNIVERSITY OF EAST LONDON

Consent to participate in a research study

“Out of the black box: investigating the experiential impact of psychotherapy with refugees on interpreters”

I have read the information sheet relating to the above research study and have been given a copy to keep. **YES/NO**

The nature and purposes of the research have been explained to me, and I have had the opportunity to discuss the details and ask questions about this information. I understand what is being proposed and the procedures in which I will be involved have been explained to me. **YES/NO**

I understand that my involvement in this study, and particular data from this research, will remain strictly confidential. Only the researcher(s) involved in the study will have access to identifying data. It has been explained to me what will happen once the research study has been completed. **YES/NO**

I understand that I have the right to withdraw from the study at any time without disadvantage to myself and without being obliged to give any reason. I also understand that should I withdraw, the researcher reserves the right to use my anonymous data after analysis of the data has begun. **YES/NO**

On date, I hereby freely and fully consent to participate in the study which has been fully explained to me.

Participant's Name

Researcher's Name

.....

Martina Di Braccio

Participant's Signature

Researcher's Signature

.....

.....

Appendix I: Debrief Letter



Dear Participant,

Thank you for taking the time to participate in this research study. This study aims to explore how interpreters experience psychotherapy with refugees, if and how it affects them, and how they would like to be supported. My hope is that this study will inform better support resources for interpreters.

Please keep hold of the information letter provided which outlines how your data will be used, stored, for how long and how your privacy will be protected. If you want to withdraw from the study, I would be grateful if you could let me know within 3 weeks. I remind you that I won't be able to exclude your interview data once it has been analysed.

If you have any questions regarding this study, please feel free to contact myself (Martina Di Braccio: [REDACTED]) or my supervisor (Dr Nicholas Wood: [REDACTED]).

I am aware we discussed a sensitive topic. In the event that you feel psychologically distressed after the interview, I suggest you contact one of the below organisations which may be able to help. Alternatively, you can visit your GP who can suggest other services local to you.

SAMARITANS Support Telephone Line (24/7): 0116 123; Website: www.samaritans.org

SANE Emotional Support Service (4.30pm-10pm daily): Via phone: 0300 304 7000; via their website: www.sane.org.uk

Many thanks again for your contribution

Yours sincerely,

Martina Di Braccio

Appendix J: Notice of Ethics Review Decision

School of Psychology Research Ethics Committee

NOTICE OF ETHICS REVIEW DECISION

For research involving human participants

BSc/MSc/MA/Professional Doctorates in Clinical, Counselling and Educational Psychology

REVIEWER: [REDACTED]

SUPERVISOR: Nicholas Wood

STUDENT: Martina Di Braccio

Course: Professional Doctorate in Clinical Psychology

Title of proposed study: TBC

DECISION OPTIONS:

1. **APPROVED:** Ethics approval for the above named research study has been granted from the date of approval (see end of this notice) to the date it is submitted for assessment/examination.
2. **APPROVED, BUT MINOR AMENDMENTS ARE REQUIRED BEFORE THE RESEARCH COMMENCES** (see Minor Amendments box below): In this circumstance, re-submission of an ethics application is not required but the student must confirm with their supervisor that all minor amendments have been made before the research commences. Students are to do this by filling in the confirmation box below when all amendments have been attended to and emailing a copy of this decision notice to her/his supervisor for their records. The supervisor will then forward the student's confirmation to the School for its records.
3. **NOT APPROVED, MAJOR AMENDMENTS AND RE-SUBMISSION REQUIRED** (see Major Amendments box below): In this circumstance, a revised ethics application must be submitted and approved before any research takes place. The revised application will be reviewed by the same reviewer. If in doubt, students should ask their supervisor for support in revising their ethics application.

DECISION ON THE ABOVE-NAMED PROPOSED RESEARCH STUDY

(Please indicate the decision according to one of the 3 options above)

APPROVED

Minor amendments required *(for reviewer):*

Major amendments required *(for reviewer):*

Confirmation of making the above minor amendments *(for students):*

I have noted and made all the required minor amendments, as stated above, before starting my research and collecting data.

Student's name *(Typed name to act as signature):*

Student number:

Date:

(Please submit a copy of this decision letter to your supervisor with this box completed, if minor amendments to your ethics application are required)

ASSESSMENT OF RISK TO RESEACHER *(for reviewer)*

Has an adequate risk assessment been offered in the application form?

YES

Please request resubmission with an adequate risk assessment

If the proposed research could expose the researcher to any of kind of emotional, physical or health and safety hazard? Please rate the degree of risk:

HIGH

Please do not approve a high risk application and refer to the Chair of Ethics. Travel to countries/provinces/areas deemed to be high risk should not be permitted and an application not approved on this basis. If unsure please refer to the Chair of Ethics.

MEDIUM *(Please approve but with appropriate recommendations)*

LOW

Reviewer comments in relation to researcher risk (if any).

Reviewer (*Typed name to act as signature*): [REDACTED]

Date: 17.04.2019

This reviewer has assessed the ethics application for the named research study on behalf of the School of Psychology Research Ethics Committee

RESEARCHER PLEASE NOTE:

For the researcher and participants involved in the above named study to be covered by UEL's Insurance, prior ethics approval from the School of Psychology (acting on behalf of the UEL Research Ethics Committee), and confirmation from students where minor amendments were required, must be obtained before any research takes place.

For a copy of UEL's Personal Accident & Travel Insurance Policy, please see the Ethics Folder in the Psychology Noticeboard

Appendix K: Confirmation of Ethics Minor Amendment

UNIVERSITY OF EAST LONDON

School of Psychology

REQUEST FOR AMENDMENT TO AN ETHICS APPLICATION

FOR BSc, MSc/MA & TAUGHT PROFESSIONAL DOCTORATE STUDENTS

Please complete this form if you are requesting approval for proposed amendment(s) to an ethics application that has been approved by the School of Psychology.

Note that approval must be given for significant change to research procedure that impacts on ethical protocol. If you are not sure about whether your proposed amendment warrants approval consult your supervisor or contact [REDACTED] [REDACTED] (Chair of the School Research Ethics Committee).

HOW TO COMPLETE & SUBMIT THE REQUEST

1. Complete the request form electronically and accurately.
2. Type your name in the 'student's signature' section (page 2).
3. When submitting this request form, ensure that all necessary documents are attached (see below).
Using your UEL email address, email the completed request form along with associated documents to: XXX
4. Your request form will be returned to you via your UEL email address with reviewer's response box completed. This will normally be within five days. Keep a copy of the approval to submit with your project/dissertation/thesis.
5. Recruitment and data collection are **not** to commence until your proposed amendment has been approved.

REQUIRED DOCUMENTS

1. A copy of your previously approved ethics application with proposed amendments(s) added as tracked changes.
2. Copies of updated documents that may relate to your proposed amendment(s). For example an updated recruitment notice, updated participant information letter, updated consent form etc.
3. A copy of the approval of your initial ethics application.

Name of applicant: Martina Di Braccio

Programme of study: Doctorate, Clinical Psychology

Title of research: Out of the black box: investigating the experiential impact of psychotherapy with refugees on interpreters

Name of supervisor: Nicholas Wood

Briefly outline the nature of your proposed amendment(s) and associated rationale(s) in the boxes below

Proposed amendment	Rationale
Interviews to also be offered via Phone or Skype if participants are unable to travel to meet face to face	Difficulty recruiting male participants who can attend face to face

Please tick	YES	NO
Is your supervisor aware of your proposed amendment(s) and agree to them?	YES	

Student's signature (please type your name): Martina Di Braccio

Date: 14th of October 2019

TO BE COMPLETED BY REVIEWER		
Amendment(s) approved	Yes	
Comments		

Reviewer: XXXXXXXXXX

Date: 16.10.19

Appendix L: Example of Coded Transcript

Transcript Section	Identified Codes
<p><i>I: what about specifically to therapy what are the challenges of that?</i></p> <p>Andrea: to translate for that that kind of setting? A few practical things come to my mind if the service user is receiving this for the first time and it is majority of the cases here. The terminology and so, I need to up myself or give some kind of background to this person for example what is.. because some terms are even new to me and then if I translate direct way, it doesn't make sense. So, that is sometimes difficult. How can this be overcome which it happens and I say need to ask more explanation from the professional, so professional explains the term maybe the lay persons' term, then I translate that and I find, for example, difficult to translate those questionnaires two reasons again, one as a service user myself at one stage and that is, you know those.. "How do you feel in the last one week one to five" and it's tiring and after a while you lose concentration, that's three? Four? like it's a mathematical entity. And I feel actually it's happening the same way with the client, they are getting tired and also the questions are some of them very similar. So what I have asked recently to betters my translation of it, so it feels real in [Middle Eastern Language], I asked some blank forms. So I will work on them at home with other [Middle Eastern] people so maybe it sounds more real life the questions rather than "Did you feel okay about yourself" that kind of thing? And I think I would say a second reason, I think I already mentioned it, I think the client sometimes feels sceptical and I feel weirdly like dutiful that I should be just questioning and also I want to convey that her or his tiredness but then again I remember my job is not that.</p> <p><i>I: you mean with the questionnaires specifically?</i></p> <p>Andrea: yes questionnaire specifically because then people here or in general professionals are professional enough to read the body language and voice. Even if they don't know the words.</p> <p><i>I: What about the emotional impact of specifically working in therapy?</i></p>	<p>Interpreting psychological constructs and feelings Cultural brokering Keeping focused Going beyond the role Feeling pulled to do more Invisibility</p>

Andrea: Yes.. it's a couple of things. Sometimes I am I am carrying the burden of the service user in the sense that is my presence too much for that person. Like, if I wasn't here, would he or she be more comfortable directly. And so I try to conduct myself, because sometimes we sit over there, they talk to me outside here and you have seen that lovely client of one person will be hugged each other. So I am mindful and keep thinking in the background that this closeness or warmth is a burden for them preventing maybe some very shameful things in front of me, can they say or not? Or if I am too detached and like I don't know, urban elites and then that again, is it a deterrent for the client to say certain.. so sometimes I think "Am I too much in this room between two people?" I know I am again, relaying words but a little more than that. Within that setting, it's not a housing appointment, it is not.. it is very private thing between two people and I am there as a third person, necessary but all the time I'm thinking how I am coming across, who knows? Is my face too sad, and I look at the mirror at home because I know, I am sometimes sad face listening, but does it affect that person? So that kind of I think it's good to question and keep yourself on toes. But of course, it's not like, I come out come here one hour I translate and finish though it is before and after and during. And sometimes I reflect "shit, I could do this better" later on

I: How do you manage this balance that you're telling me about?

Andrea: If I get a good feedback not necessarily with words, but like, for example, rebooking or client wanting me and client not wanting anybody else if I'm on break or cancelling their appointment because just because I am not there. So these are good signs. So I think "oh, okay, I am doing good". And a couple of times for example, here, they told me probably they tell other interpreters as well. Because I have been seen speaking chatting to clients outside, and of course very rightly so, they want to know they need to know about if I'm observing the boundaries. And I think I'm good good with it. And I like the fact that the professionals here they ask me, so it's not like let loose. I like this care and I just assure that I don't ask any private questions, even "which the do you come from?" or "which organisations you go to?". Because I am from the same community, so I don't want to pick private things from them. And also, I am quite comfortable to decline to answer some private questions about me. Because I don't want to alienate anybody.

Being too much in the room
 Invisibility
 Being human towards the client
 Wanting to learn and develop

Gaining the clients' trust
 Complex negotiation of boundaries
 Being held in mind
 Belonging to the same community
 Being human towards the client

Appendix M: List of Codes and Associated Themes

N. of codes extracted from NVivo: 221

N. after correcting typos and merging similar codes: 135

Code	Sub-Theme	Theme
Absolute confidentiality Belonging to the same community Gaining the client's trust	Trust and Confidentiality in Political Contexts	What is my Role?
Avoiding personal rapport Complex negotiation of boundaries Cultural brokering	Negotiating Cultural Boundaries	
Client's engagement Different skills and requirements in different settings Interpreting psychological constructs and feelings Interpreting the emotion Neutrality Keeping focused Linguistic skill The complexity of language interpreting Therapy has specific challenges Understanding the context	Challenges of Interpreting in Therapy	
Being human towards the client Being invisible Being there for the client Being too much in the room Conveying the message Delivering the exact message Facilitating communication Facilitating Engagement Feeling angry at the provider Feeling pulled to do more Going beyond the role Just the translation Making the client feel better Transparency	Just the Words vs Going Beyond	

Code	Sub-Theme	Theme
<ul style="list-style-type: none"> Affecting the view of the world An emotionally draining profession Difficult material Feeling staying with me Hearing what the client has been through Seeing social injustice closely Therapy not going well 	<p>“ It Wears You Down”</p>	<p>Emotionally Connected vs Detached</p>
<ul style="list-style-type: none"> Being strong for the client Detach to survive Emotion as a hindrance to interpreting Feeling bad about needing support Feeling exposed Getting better with experience Have to be strong for the client Having to be professional Keep going Managing the emotion No impact Not my pain Not wanting to show emotion Processing after Should not get emotional Switching into the role Switching off 	<p>Being Strong / Switching off to Survive</p>	
<ul style="list-style-type: none"> Juggling personal and professional life Keeping the balance Pacing the work Personal life Self-care Support in personal relationships Trusting the client is in good hands Unwind 	<p>Maintaining the Balance</p>	
<ul style="list-style-type: none"> Client's emotions Client's social struggles Delivering bad news Emotion as a strength Feeling emotional Feeling with the client Hearing what the client has been through Making sense of the client's story Not a robot Putting myself in client's shoes Ready for anything Sharing a migrant background, being able to relate Wondering what happened to the client 	<p>Being Human with the Client</p>	

Code	Sub-Theme	Theme
Coming together with other interpreters	Dealing with Things alone vs Receiving Personalised Support in Safe Spaces	Current Context vs Aspiration
Expert advice		
Inappropriate support		
Limited interaction with other interpreters		
Needing a qualified person		
Not being entitled to support		
Not expecting support from the therapist		
Not needing support		
Paying for support		
Personal responsibility		
Safe space		
Specific support for mental health		
Taking the clinical route		
Wanting what therapists get		
Alone with the feeling		
Choice of support		
Coming together with other interpreters		
Being on the go		
Charity's financial limitations		
Coordinating the work		
Declining profession		
Entering the career by chance		
Feeling like I have not done enough		
Flexibility		
Government cuts		
Interpreters needed less		
Job Security		
Lack of stability		
Not a career		
Occupational benefits		
Poor quality interpreting		
Poor regulation of the profession		
Poor wages		
The profession being more protected		

Code	Sub-Theme	Theme
A greater purpose Being inspired by the client Developing as a person Feeling honoured Getting better with experience Gratitude Learning from each other Learning from the therapist Meeting different people Professional development Seeing the client getting better Self-betterment Wanting to learn and develop Working with people	Purpose and Growth	Current Context vs Aspiration
Being held in mind Being part of a team, family Being prepared for the session Feeling accepted and trusted Feeling ignored Feeling trusted by the therapist Feeling valued Just the interpreter Making therapy possible Not anyone's priority Not on the political agenda Therapist not wanting an interpreter Working together with the therapist	Being "Just" the Interpreter vs Being Trusted, Valued and Included	

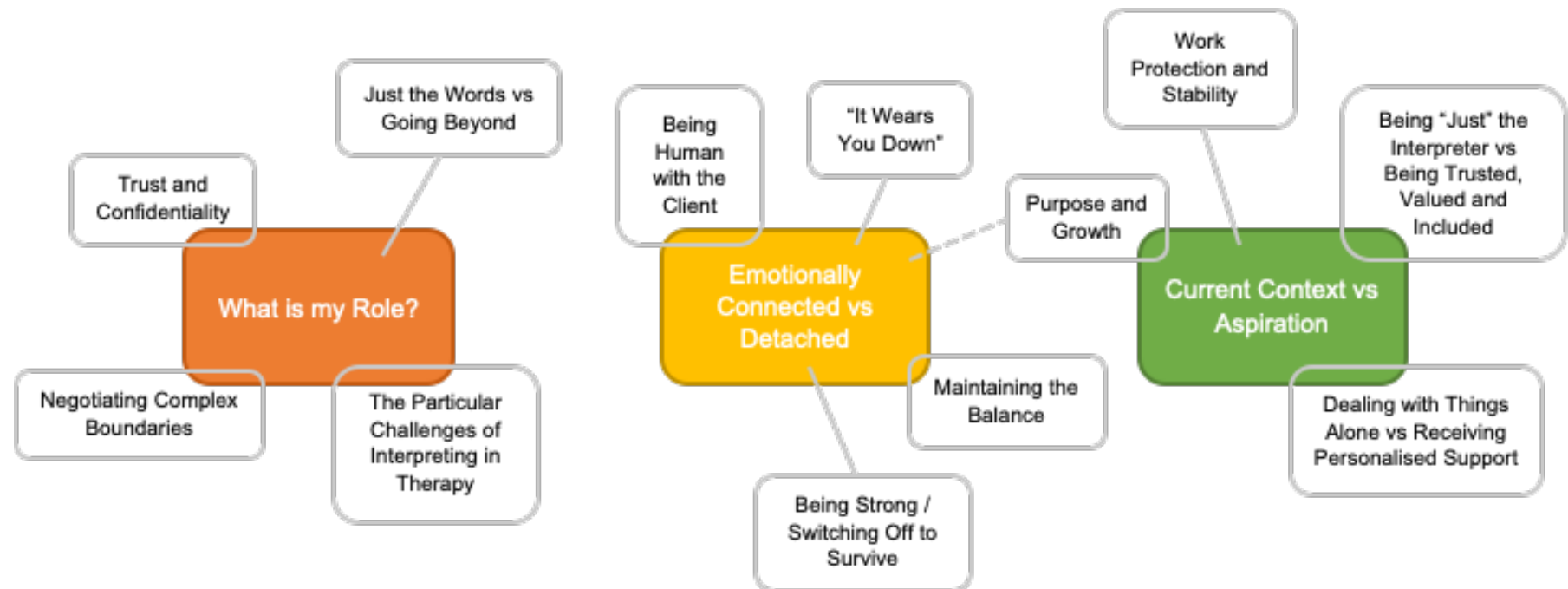
The therapist being in control of the session **Discarded**

Appendix N: Initial Thematic Map



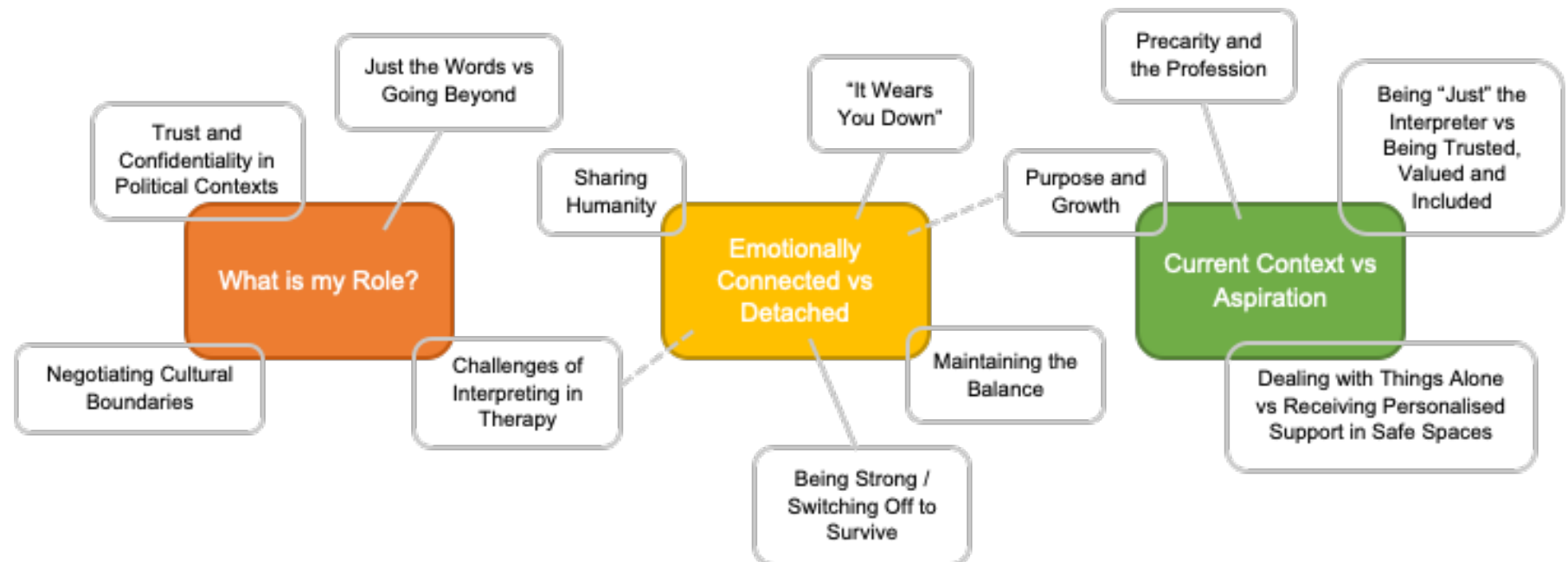
Appendix O: Second Iteration Thematic Map

The initial thematic map was reviewed against the raw data and some bipolar themes were introduced to provide a further sense of chronological and semantic continuum of participants' experiences:



Appendix P: Final Thematic Map

The map was further edited after reflections with the supervisor on the need to bring forward the cultural and political nuances of 'Trust' and 'Boundaries':



Appendix Q: Reflective Diary Extract

Interview 1 & 2 (Andrea and George, held on the same day)

Pre-interview reflections

I felt quite nervous before starting these first interviews. I was anxious about looking incompetent or being too leading and I was worried I would struggle to meet for long enough (“will we have enough to talk about?”). The interview with Andrea was delayed so anxiety was building up as I feared the offices would close and we wouldn’t have enough time. The room also felt quite noisy, I thought “will the recorder pick up the voice?”.

Post Interview Reflections

I feel like they overall went okay for being the first ones. I am so surprised at how different these two interpreters are in the way they approach their work. George appears more detached and talked a lot about remaining impartial and not judging whether one’s torture story is true or not, he appeared to switch a lot to talk about legal context where he appeared more experienced. Andrea was had a lot more of an empathic approach and appears very passionate about the work in therapy. She became emotional talking about the impact of the work and how hard it is to hear the horror happening in the world. She was very apologetic about it. She referred to getting emotional as not being professional, also George talked like emotion was to avoid at all cost.

I think my nervousness came across with Andrea more, as I was worried we were running out of time and we had to leave the room. I also felt under pressure to ask the right questions because she seemed to have so much to say, I did not want to “ruin” the interview. I also really liked her as a person and really wanted her to feel comfortable. I still feel I could have explored things a bit more rather than jumping to the next question for fear of not having enough time – to keep in mind for the next interviews. I also summarised what they were saying a couple of times to elicit more content, like in therapy sessions - to be mindful of that during the next interviews. When Andrea became emotional I had to tell myself not to jump in a “psychologist mode” while being also

maintaining rapport and I think I managed that okay. With George I was very surprised at how pragmatic and technical he was and how he reported being unaffected about the work. I hope that surprise did not come across as his interview definitely challenged my prior views. The interview with George was quite short but he still shared quite a lot, I am glad I decided to close the interview early as he said a couple of times “as I said...”. I think my questions were getting a bit repetitive towards the end.