The British Psychological Society

Professional Practice Board

Working with Interpreters in Health Settings

Guidelines for Psychologists

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Contents

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Executive summary

Working effectively with interpreters should be a skill which every psychologist possesses. This is to ensure that equal opportunities are upheld and that certain groups are not denied access to psychological services. To achieve this aim, all psychologists should receive training in working with interpreters as a core part of their professional training. If this is not available within your trust, it is recommended that this is undertaken as part of your ongoing continuing professional development. Training courses are available in much of the country. These good practice guidelines give an overview of the issues psychologists need to consider when working with interpreters to ensure that they are able to be as effective as possible.

Key recommendations for practice

- Undertake a language needs analysis for the population which your service covers and consider how you will best meet this need.
- If you have not undertaken training in working with interpreters, undertake a training course, If this is really not feasible as you will be working with an interpreter unexpectedly, read the guidelines and allocate time to consider the issues or discuss them with a more experienced colleague in advance of your first session with an interpreter. Psychologists should consider attending deaf awareness training run by their NHS trust in advance of working with a British Sign Language Interpreter (BSLI).
- Check that the interpreter is qualified and appropriate for the consultation/meeting.
- Allocate 10–15 minutes in advance of the session to brief the interpreter about the purpose of the meeting and to enable them to brief you about any cultural issues which may have bearing on the session.
- Be mindful of issues of confidentiality and trust when working with someone from a small language community (including the deaf community) as the client may be anxious about being identifiable and mistrustful of an interpreter's professionalism.
- State clearly that you alone hold clinical responsibility for the meeting.
- Create a good atmosphere where each member of the triad feels able to ask for clarification if anything is unclear and be respectful to your interpreter, they are an important member of the team who makes your work possible
- Match when appropriate for gender and age, do not use a relative and never use a child.
- Be aware of the well-being of your interpreter and the possibility of your interpreter suffering from vicarious traumatisation; consider what support they will be offered.
- At the end of the session allocate 10 minutes to debrief the interpreter about the session and offer support and supervision as appropriate.

- All written translations used should have been back translated to ensure they are fit for purpose.
- Extreme caution should be exercised when considering the use of translated psychometric tests.
- Commissioners need to ensure that there are clear pathways to support for all members of their local community including those who do not speak English.

Introduction

Avoiding discrimination by ensuring equal access to psychological therapy to non-English speakers must be a fundamental aim. Working with an interpreter and communicating through a third person can feel like a challenge and it may require enhancing your repertoire of skills as a psychologist. However, there can be definite gains in developing your skills in this area. For example, working with an interpreter may assist with learning about different views of psychological well-being, forms of client presentation, idioms of distress, explanatory health beliefs and world views. Becoming skilled at working with an interpreter will also enhance service delivery through ensuring that access to psychological services is not limited to those fluent in the English language, irrespective of need.

Language is a multifaceted, rich and complex phenomenon which forms one of the cornerstones of human communication and should be accorded particular attention in providing client services. Interpreters are often not recognised for the unique skills and expertise that they can contribute in enabling psychologists and clients/service users to communicate with one another. Working with deaf clients who use sign language as their first language likewise requires specialist skills due to the need to consider a visual language rather than a spoken language.[1]

It is essential to consider the context when working with an interpreter. Being unable to fluently speak the language of the country you are currently living in or having difficulties with hearing can be frightening and disempowering experiences. Racism and power differentials can also play a role and appropriate provision for all clients needs to be considered in providing interpreters.

It is good practice to offer all clients whose first language is not English the option of using an interpreter. Otherwise, individuals may not realise that they can have a professional interpreter and may try to manage without one, creating difficulties in communication. At the same time, it is important to recognise the difficulties many non-English speaking clients can have in using interpreters for fear of breaches of confidentiality, especially where the interpreter might be from the same community-based ethnic group. Thus, it is crucial to offer a choice about interpreter and to find ways to explore this choice with your

[1] It may also be useful to invite clients to attend sessions with other people who might aid their communication abilities, for example clients with learning disabilities, aphasia or dysarthria might benefit from attending sessions with a support worker who is more familiar with their style of communication and can offer clarity to the clinician.

clients, weighing up the need for clear communication against any other competing considerations.

A multilingual appointment card can be downloaded from www.harpweb.org.uk . In the case of deaf clients, it is equally important to ensure that appropriately trained sign language interpreters are made available.

The guidelines are divided in to 12 sections for ease of reference. A number of references are interspersed through out the text, so that the interested reader can follow up these points if they so wish.

These good practice guidelines provide some working principles to help inform and direct practice. They do not, however, attempt to cover every eventuality which may occur when working with an interpreter. The reader may need to refer to these guidelines in conjunction with the underlying Society and divisional professional practice and ethical guidelines.

The exact relationship between language and meaning is still contested. Many theorists argue that language not only transmits meaning but also constructs and shapes it at the individual and societal level (Anderson & Goolishian, 1992; Burr, 1995; Mudakiri, 2003) and this should be kept in mind when working with an interpreter. The psychological relationship between a person's first language and a second or subsequent language is also an area of debate (Antinucci-Mark, 1990; Antinucci, 2004). This may carry particular resonance when working with interpreters and this should also be considered.

When working with deaf clients it is recommended that the clinician should educate themselves about deaf culture and deaf identity through a local deaf awareness programme (either within a NHS Trust or externally). Deaf people's experiences of spoken language may have been influenced by the way they were educated, their family background, whether they learnt sign language as a child, or whether they were encouraged to use their voice and to lip-read (often called an 'oralist' approach). It must also be remembered that around 90 per cent of deaf people are born into hearing families.

Similarly, it is helpful for psychologists to seek to educate themselves about the cultural background of a non-English speaking client both through their own research and through exploration with their clients and interpreters. This may be particularly pertinent when working with survivors of persecution and violence. It is important to be mindful of the way in which power differentials originating in the country of origin may affect the relationship between psychologist, interpreter and client, particularly in the light of political and social conflict.

It is also important for service providers to consider the ways in which they might support the interpreters they use. As Lipton et al. (2002) point out, interpreters may work with seriously traumatised clients, with possible psychosocial consequences as a result. Few have had a comprehensive mental health training which would cover such topics as boundaries and self-care, and may thus be very susceptible to vicarious traumatisation (Tribe & Morrissey 2003). Further, interpreters frequently find themselves obliged to convey very difficult information to clients, for example explaining that a client is to be detained in a psychiatric hospital, has been given a particular diagnosis or prognosis, or is being given a custodial prison sentence. All these outcomes can have serious or life-changing

implications for the client and it may be difficult for the interpreter to handle such a challenging role. Professionals should recall that interpreters are entitled to support in the same way as any other professional colleague and a duty of care applies, whether or not they are employed by an outside agency, and employment responsibilities cover all employees (Management of Health and Safety at Work Regulations, 1999). Suggestions for supporting interpreters and providing adequate supervision are offered in section 7.

The guidelines

1. Relevant guidelines and legislation

There is extensive international and national legislation that advocates for equality of access to health and legal services, although in many instances the use of interpreters is not always clearly articulated. Legal frameworks that advocate for equality of access to health services include:

- European Convention for the Protection of Human Rights and Fundamental Freedoms (1950)
- The United Nations Convention of the Rights of the Child (1989)
- Human Rights Act (1998)
- Race Relations Amendment Act (2000)
- The Disability Discrimination Act (1995) and the Disability Discrimination Act (2005)

There are a number of policy documents that promote equal access to health and some of these specifically mention access to interpreters. Legislation in England includes:

- The National Service Framework for Mental Health, which emphasises the importance of interpreting services across all seven standards.
- The Mental Health Act Code of Practice clearly instructs local and health authorities to ensure that approved social workers and doctors receive adequate guidance in the use of interpreters and to make arrangements for easy access to trained interpreters.

As a general principle, it is the responsibility of the psychologist to ensure effective communication between themselves and the service users.

2. Booking/finding an interpreter

2.1. Language Needs Analysis

Psychological service providers may need to consider conducting a formal needs assessment relating to interpreting services. This might include obtaining baseline data on the language needs of the communities they serve, including British Sign Language (BSL), and a review of the languages used by relevant clinical staff to ensure that they make optimal use of the language resources they have available. They should also consider whether the needs of their population are best served by employing interpreters, advocates or bilingual link workers directly or by using external interpreting services.[2]

When offering psychological services to deaf people it is advisable to have regard to the Disabilities Discrimination Act and the responsibilities under this Act. Local mental health services should contact any of the three national deaf services for advice.[3]

2.2 Locating an appropriate interpreter

As stated, it is a matter for each organisation/service provider to decide whether to employ a team of in-house interpreters and health advocates or use an interpreting agency, ensuring that any interpreting agency meets the appropriate quality criteria and is accredited by the relevant body.

The professional concerned should find out the client's first language and try to book an interpreter who speaks this language, ideally from the same country, and when necessary a speaker of the same dialect as the client. Do not assume that someone who speaks a language can speak/understand it in all the dialects (Marshall et al., 1998; Tribe with Sanders, 2003). (A guide to languages by country can be found at www.ethnologue.com/country_index.asp).

The interpreter should not only be fluent in two languages but have an understanding of the two different cultural contexts (Tribe & Raval, 2003; Razban, 2003). Ideally they should have undergone recognised language testing to ensure that they are fluent and have relevant experience for the task. In Britain, the Register of Public Service Interpreters (www. nrpsi.co.uk), the Institute of Linguists, (www.iol.org.uk) and the National Language Standards (www.cilt.org.uk/standard/languages.htm) would be the organisations to contact and can assist in locating a suitably qualified interpreter.

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[2] Health advocates are employed by many NHS trusts. In addition to language interpreting they are employed to advocate for the individual by ensuring that their needs are understood and met. BSL interpreters and advocates for deaf people are two separate professions.

[3] The three national deaf services for England and Wales are: a) Old Church, Balham, London, b) Denmark House, Queen Elizabeth Psychiatric Hospital, Birmingham, and c) John Denmark Unit, Prestwich Hospital, Bury, Manchester. For more information on working with deaf people in a mental health setting see the NIMHE report *Mental Health and Deafness, Towards Equality and Access* (2005) http://www.dh.gov.uk/en/Publicationsandstatistics/Pressreleases/DH_4104006.

In the case of deaf clients, it is important to ensure that the interpreter is registered with CACDP's independent registration Panel (IRP) http://cacdp.org.uk/interpreters/online_directory/online- directory.html)[4] and is a member of the Register of Sign Language Interpreters (MRSLI); they may also be registered with the Association of Sign Language Interpreters (ASLI) http://www.asli.org.uk.

It may also be important to make some assessment of a deaf client's fluency in using sign language. Some deaf people, and perhaps a high proportion of those needing mental health support, may not be fluent in sign language due to the delay in their opportunities to learn BSL. Educationalists have often promoted an 'oral' approach to deaf education, and this has prevented deaf children from learning to sign because of the belief that this will interfere with their ability to learn spoken and/or written English. In reality, many deaf children have been drawn to signing as a natural method of communication in the playground or outside of school. Others, who may have been to a mainstream school, may not have had this opportunity and have consequently learnt BSL as an adult after leaving school, perhaps through attending a Deaf Club. Hence for some deaf people their signing may be not fluent, but this may only be an indication of their particular situation rather than a learning disability or a mental health difficulty.[5]

As a general rule, it is not appropriate to ask family members or other professionals to 'help out' because they appear to speak the same language as the client or have sign language skills. Interpreting is a highly skilled role and not something that any person or even any professional can just slip into (Sande, 1988; Vasquez & Javier, 1991; Pochhacker, 2000). The use of family members also creates difficulties with regard to confidentiality (Juckett, 2005) although some clients may insist upon it. This should be discussed with

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[4] The RNID can also offer support in finding a sign language interpreter for deaf individuals and they can be found at http://www.rnid.org.uk, telephone 0808 808 0123, e-mail: information@rnid.org.uk.

For more information on working with interpreters in British Sign language see http://66.102.9.104/search?q=cache:G1iKfmvdc9UJ:www.aucc.uk.com/journal_pdf/aucc_summer_3.pdf+deaf+interpreters+in+the+mental+health+setting&hl=en

[5] It may be useful to consider working with an experienced deaf communication facilitator (DCF) or deaf relay interpreter as well as a sign language interpreter if the service user's sign language is dysfluent through any significant language delay during childhood or an actual learning disability. A deaf communication facilitator is a deaf person who is a native BSL user, and who has experience of communicating effectively with a variety of deaf people with varying levels of language ability. A DCF will be able to break down complex signed phrases into simpler ones, enabling a deaf service user to understand the concepts being discussed. Working with a DCF will change the dynamics in the room as yet another person is put into the chain of communication between you and the service user. However, this may benefit the service user who may feel more comfortable with another deaf person in the room helping them to be more effectively involved in the communication. This may balance the cultural identities and power differentials in the room with two hearing people and two deaf people.

them. Children, however, should never be used as interpreters as this places them in a difficult and prematurely adult role towards their parent or relative.

If your client refuses a professional interpreter and comes with a non-professional to interpret (even if this is a family member or friend), it is important to make clear to them that they can have a professional if they want, and that you are clear why they might prefer someone they know. Bear in mind in any work that you do with a non-professional that they may not be as skilled in English, or indeed in their native tongue and they may have little or no experience of, or training in interpreting. They may be unclear about such issues as confidentiality, boundaries and the use of good interpreting skills. They may also have their own agenda about the client and wish to tell you more or less about the client than the client themselves would wish (Thompson & Woolf, 2004).

In some cases, using a non-professional interpreter may help you establish an atmosphere of trust or set the scene for some psychological work in such a way that you can then negotiate with the client to introduce a professional interpreter (Thompson & Woolf, 2004).

In many cases individuals may come from small ethnic communities and as a result their interpreter may be known to them from other settings. This can create complications. In the case of deaf individuals, the deaf world is a small one (about 60,000 deaf BSL users in UK) and the sign language interpreter population is even smaller (about 450 to 500 registered in UK), making it quite possible that an interpreter has interpreted for any given service user before. In both language and sign language interpreting work, this familiarity may be acceptable (or even preferred) by the service user. However, it is always important to explore whether the service user and interpreter know each other and whether there are concerns about the level of confidential information that may require to be shared.

Some writers have suggested that it can be helpful to match for gender, age and religion between language interpreters and clients when possible (Nijad, 2003). This can be particularly relevant, for example, in the case of sexual assault or domestic violence or when discussion of taboo areas may be necessary. However, clients can differ in their requirements and it is important to offer a choice and assess individual requirements. This can readily be done at the same time as you ask the client about what language would be most suitable for them, perhaps by sending an easily completed form with their initial appointment letter. It should also be acknowledged that while offering a choice may be the ideal, it is not always possible to ensure this.

In some trusts, there may be pressures to make use of telephone rather than face-to-face interpreting services, although the experience of clinicians would indicate that this form of interpreting has limited value for psychological therapy, or for health-related work in general. Nevertheless, there may be occasions when it is helpful to use telephone interpreting, for example when rescheduling appointments, in crisis situations or when there is a need to establish consent to treatment.

2.3. Training issues

It is argued that the provision of appropriate training for both practitioners and interpreters, as well as the use of effective guidelines can produce improvements in service provision (Tribe, 1999). More experienced interpreters tend to recognise this need, and

are more likely to advocate training both for themselves and for the professionals for whom they interpret (Granger & Baker 2003). Baker et al. (2008) note that the same applies to BSL interpreters, although training for professionals working with BSL interpreters has not yet been established. Further, many of the difficulties described when working with language interpreters in mental health seem to arise as a result of inadequate training for both parties. Tribe and Raval (2003) provide a template for a possible training curriculum.

Both interpreters and psychologists require appropriate induction in working together even if an outside agency is providing interpreters. Running appropriate training and information sessions ensures that the interpreters are conversant with the organisation's aims, objectives and culture and may also provide an integrating function. (Kiramayer et al., 2003; Tribe & Morrissey, 2003; Williams, 2005). Joint sessions where professionals and interpreters are trained together allows a better understanding of each person's role as well as the development of a genuine sense of co-working.

3. Preparation before the consultation/meeting

Try to spend some time considering all the implications of working with a third person (the language or sign language interpreter/bicultural worker) before the consultation/meeting. It can be useful to discuss this with an experienced interpreter or, failing that, with colleagues who have experience of working with interpreters.

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

It is also important to ensure that an interpreter is fully aware of all issues relating to professional boundaries. For example, does the interpreter know that it is preferable that if they are to undertake a number of therapeutic sessions that they should not interpret in any other situation for the client as it could blur boundaries and might trigger feelings from within the therapeutic sessions and may be contra indicated?

3.1 Changes to the dynamics of therapeutic work

A service user may have anxieties about being dependent on another person, the interpreter, to act as their voice and to explain their emotions. Some clients have reported feeling infantalised by this process (Tribe, 2007). Service users may also have anxieties about confidentiality. Alexander et al. (2004) have noted that the issue of personal trust was seen as paramount by service users in a study examining access to services with

interpreters. A psychologist working with an interpreter will need to be aware of this possibility, and to consider how this may impact on their work and how to deal with it.

Working with an interpreter as a conduit also makes you dependent on another person, and this can change the dynamic of the meeting. Clinicians sometimes report feeling anxious in this situation or excluded from the interaction which can feel as though it takes place between the client and the interpreter. Some writers have noted that transference and countertransference reactions can be more complex (Spector et al., 2007): *'Unlike the dyadic clinician–patient model and its single relationship, the triangle clinician–interpreter-patient model involves three relationships. Thus, it is 200 per cent more complex and involves the patient's transference to both clinician and interpreter, countertransference among both of the latter toward the patient, and the co-worker relationship between clinician and interpreter'* (Westermeyer, 1990, p. 747). In fact, it may be that thinking in terms of transference and countertransference is not the most helpful in a three-way interaction and clinicians may find it more helpful simply to reflect on the complex emotional reactions in the room (Miller et al., 2005). There can be a sense of two overlapping dyads (perhaps the clinician and interpreter or the interpreter and client) rather than the three parties working and communicating in a good three-way therapeutic relationship. The best way to manage such developments is to reflect upon them, both in supervision (for the clinician) and in conversation with the interpreter, who may be able to feed back other aspects of the dynamics and may need help in managing or containing these.

When working with interpreters it is important to pay particular attention to the change in the dynamics which the presence of an interpreter can bring. In the case of language interpreters there may be an assumed alliance between the interpreter and the psychologist through sharing a language and a perceived position of power by the client. The psychologist can feel threatened by being in a triad as opposed to a dyad and once removed from the words which are being spoken in the consultation. With sign language interpreters, it is useful to remember that the interpreter is a hearing person, like the majority of psychologists. This may affect the dynamics within the room as there will be two hearing people (with privileged positions in a dominant hearing society) and one deaf person (with a less privileged position and frequent experiences of being excluded by hearing people). Most interpreters will have some awareness of this dynamic, but it is important to reflect on the interactions within the session. Likewise, it is also possible that the service user will be suspicious of all hearing people, and maybe sign language interpreters in particular, perhaps accepting them only as a necessary evil, while there is an additional dynamic of perceived alliance between deaf people and interpreters on the part of health professionals, who may see them as sharing a common language and understanding of deaf culture.

3.2. Language and culture

Oquendo (1996) notes that cultural nuances may be encoded in language in ways that are not readily conveyed in translation. In general, the languages being used need to be thought about and it can be helpful to discuss these issues with native speakers, including your interpreter, in advance of the session. This also makes sense when considering the use of visual components of British Sign Language (e.g. facial expressions, body movements,

etc.) and bringing your reflections on this into your consideration of the psychological process of your work.

Similarly, it is helpful to remember that languages are not directly interchangeable; meanings may be coded, emotionally processed and internalised in one language and may not always be directly accessible in another (Antinucci, 2004; Keefe, 2008). There may be no appropriate word in one language for terminology that is commonplace in another. Again, native speakers, including your interpreter, may be able to guide you on this.

In addition, health beliefs and views about emotional well being, as well as idioms of distress and manners of presentation can vary with an individual's cultural and religious background. This can have important implications which need careful handling particularly when working in either mental health or forensic/legal settings (Holt Barrett & George, 2005).

In addition to the factors influencing language and culture, it must be remembered that conversation conducted using interpreters is mediated communication, mediated through an interpreter or through a second language (Holder, 2002), a process that can bring inadvertent changes. Given that interpreters must process the material with which they are dealing through their own subjective experiences, the very act of interpreting shapes the material in some way. This is a highly complex issue, and researchers have understandably encountered difficulties in trying to investigate it (Haenal, 1997; Marshall et al., 1998; Bot & Wadensjo, 2004). The communication can become altered through the mediation of the interpreter in numerous ways. One example might be when an interpreter takes it upon his or herself to interpret only part of what is said, summarising the gist for the clinician, or alternatively when a clinician has failed to explain the use of therapeutic techniques, making their style or choice of questioning hard to translate (for example, the use of circular questioning, reflective summarising, etc.). Such actions are usually an indication that the psychologist and interpreter have not had a meeting in advance of the session to clarify their roles and the stance required of the interpreter (Freed, 1988). Furthermore, the way different languages are constructed may mean that certain phrases spoken by the psychologist in English cannot be translated exactly by the interpreter to the client, thereby potentially altering the intended meaning of the initial phrase. It is important to explore with the interpreter what it would be most appropriate to do in such instances.

4. Practical considerations

The implications of using mediated communication need to be considered prior to any meeting with a client. For example:

- Remember the meeting may take longer when working with an interpreter and consider allocating additional time in advance of the meeting (Cushing, 2003; Tribe & Morrissey, 2003).
- Avoid using complicated technical language. Psychology has its own abbreviations and language, so remember that the interpreter is unlikely to have undertaken training in psychology in either of the languages used. Some medical and legal agencies find it useful to have a specialised medical or legal dictionary available. (Tribe & Morrissey, 2003).

- Words and signs do not always have precise equivalents, and a short sentence in English may take several sentences to explain in another language or vice versa. Do not become impatient if the interpreter takes longer to interpret than you would have expected. (Tribe with Sanders, 2003).
- Be wary of using proverbs and sayings. If something does not make literal sense, it is usually best avoided. That said, in some cases the use of a proverb in the client's language, or your use with them of an old English saying to illustrate something, can be very powerful in your work. This needs careful handling to make sure that the concepts have truly been understood by all parties.
- Clinicians should also be aware that it can become easy to lose concentration or to lose the thread of the session as the pace becomes slower and perhaps disjointed, given the space needed for interpretation.

If you are going to see the client for a number of sessions, try to use and book the same interpreter throughout to encourage rapport and build trust in the relationship between client, interpreter and clinician. This will make the whole process flow better, be more containing for all the participants and is likely to lead to better outcomes (Raval, 1996). A client's request to change the interpreter should be explored within the work and accommodated whenever possible. Thompson and Woolf (2004) helpfully suggest giving the client a form at the end of the first session so that they can confirm whether they are happy with the interpreter. (They can take this away, fill it in and send it back to you.) Most people can find someone to translate the form or understand a little written English and this allows them a say in whether to proceed with the interpreter offered.

Consider the layout of the room and the positioning of chairs before the session starts. In spoken language interpreting work, a triangle usually works well as the parties are equidistant and the interpreter is accessible to both the clinician and the client. In some cases, however, clinicians prefer the interpreter to sit behind the client and literally become their voice, taking a lower profile in the session (Cushing, 2003). While this is a matter of personal preference, it is important to be clear that wherever the interpreter sits, they are an active part of the therapeutic triad, and cannot be considered as a simple mouthpiece.

In sign language interpreting, it is good practice to sit next to the sign language interpreter, and opposite the service user so that eye contact from the deaf person is easily shifted between you and the interpreter. The room should be well lit with few visual distractions or bright lights that can make watching signed communication (e.g. face, eyes, hands and upper body) a strain. The ASLI should be able to advise on this.

It is important to make interpreters feel at ease and ensure that they have the best opportunity to use their language skills and cultural understandings in the service of the client (Tribe, 2005). You may wish to consider how you will do this. For example, at your initial meeting with an interpreter you can convey to them your willingness to listen to any suggestions or ideas they may have about the client. This needs to be conveyed in such a way that you make clear that you have clinical responsibility for decisions about your client's care, but welcome input nonetheless. A warm and supportive atmosphere between clinician and interpreter is likely to facilitate the therapeutic relationship for the good of the client and your work together.

Some interpreters use the first person when interpreting (saying 'I' when responding with the client's words) while others feels more comfortable to use the third person. Some authors have suggested that it is preferable to use the first person, giving a more accurate rendition of the words and emotions being expressed and conveying a better sense of immediacy (Tribe, 2005). In practice, most interpreters move between the first and third person, and it can be revealing to keep a check of this and reflect on what might be happening in the therapeutic situation to lead to such switches. If you have a preference, however, you may need to discuss this in advance with your interpreter and see what their stance is on this issue.

It is important that you create an environment where the interpreter feels able to ask for clarification if he or she does not understand what you are saying (Abdallah-Steinkopff, 1999). This can be encouraged through having a briefing session prior to the clinical consultation and leaving additional time for reflection at the end of each session. Your language interpreter is not only proficient in two languages but may be a very useful source of information about the country the client is from, the culture, the politics, the geography, the symbols and meaning relevant to the society or to particular ethnic groups, etc. It is good practice to make full use of the resource of your interpreter, something only possible if he or she is fully able to make sense of what you mean.

Baker et al. (2008) note that this is also true to a limited extent for sign language interpreters, noting that using the interpreter as a resource should only be done with caution. Most SLIs are hearing people and as such cannot share the deaf culture in the same way as a deaf person. If they are related to a deaf person (i.e. sibling or parents are deaf) then there may be transference issues present. The ideal, as noted by Baker et al. (2008), is to use a deaf communication facilitator or relay interpreter who can provide the cultural knowledge and experience described above, which may then be discussed with the interpreter. Currently deaf communication facilitators are not commonly used, and present an added dynamic which may also be unusual for a sign language interpreter to work with.

5. Preparation with the interpreter

It is rare for interpreters to have had previous training or experience of mental health work or indeed to have worked in the same speciality as the clinician. Therefore the clinician should always aim to arrange a pre-session interview with the interpreter. Spend 10 or 15 minutes on the first occasion to establish a relationship, decide how you will work together, explain the objectives of the meeting and share any relevant background information. This is an essential investment. This may also be an opportunity to clarify technical concepts, vocabulary or jargon which is likely to be used, as well as to check whether or not there are any cultural issues likely to bear on the situation. You can also decide what mode of interpreting is to be used, for example whether you will work using the linguistic (word-for-word), psychotherapeutic/ constructionist, health advocate/community interpreter or the bicultural worker mode (Tribe, 1993).

Brief definitions of these four models are:

- The linguistic mode, where the interpreter tries to interpret (as far as is possible) word-for-word and adopts a neutral and distanced position (Cushing, 2003; Tribe, 1998).
- The psychotherapeutic or constructionist mode, where the meaning/feeling of the words is most important, and the interpreter is primarily concerned with the meaning to be conveyed rather than word-for-word interpretation (Tribe, 1998b, 1999; Raval, 2003).
- The advocate or community interpreter, where the interpreter takes the role of advocate for the client, either at the individual or wider group or community level, and represents their interests beyond interpreting language for them (Tribe, 1998; Drennan & Swartz, 1999; Baylav, 2003; Razban, 2003). (This model would not normally be provided by BSL interpreters as the roles of advocate and interpreter for deaf service users have been developed as separate roles/professions.)
- Cultural broker/bicultural worker, where the interpreter interprets not only the not only the spoken word but also relevant cultural and contextual variables (Tribe 1998a; Drennan & Swartz, 1999).

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

6. During the meeting/consultation

The client may initially be uncomfortable with an interpreter being present, perhaps because of concerns about confidentiality and information reaching other members of their community, or they may be embarrassed. It may help to explain at the beginning of the first meeting that the interpreter is a professional doing their job, has no decision-making powers and is bound by the confidentiality policy of the agency and their professional body. You may also wish to explain the limits of confidentiality which relate to your place of work, for example the need to report active suicidal ideation, etc. (Tribe with Sanders, 2003).

Clients can put interpreters under considerable pressure to take on additional roles, for example to become involved in advocacy on their behalf, etc. Making clear issues of accountability and explaining the role of each party and the limitations of their responsibility assist in containing such pressures. (Tribe & Morrissey, 2003, Razban, 2003).

Look at the client as much as feels natural, rather than at the interpreter unless speaking specifically to the interpreter. In general we tend to move our eyes in a natural way between speakers but it is important to be aware of the three-way relationship and make sure that the client does not feel excluded. If your client has hearing difficulties, as stated above, it is important that you use your body positioning and eye contact to facilitate communication as much as possible.

When working with deaf service users, it is best to maintain eye-contact with them so that your communication is visually self-explanatory, although if eye contact is maintained for

too long, especially during a 'silence', the deaf person may feel that they are expected to talk as mentioned above. Appropriate eye contact is essential from the therapist and interpreter. Try to resist any temptation to talk to the interpreter, unless you are explicitly addressing them. When the interpreter is signing, try to maintain eye-contact with the service user rather than the interpreter. It often helps to speak only when signing has stopped so that everybody to be clear about who is communicating, lessening the demands on the sign language interpreter.

You may need to adjust the pace of delivery and break your speech into shorter segments, because the interpreter has to remember what you have said, translate it and then convey it to the service user. If you speak for too long, the interpreter may be hard pressed to remember the first part of your speech. Conversely, if you speak in short bursts, you may find that your speech becomes fragmented and you lose the thread of what you are saying. You will find that with open communication and trust a natural rhythm becomes established, with which everyone feels comfortable (Razban, 2003).

Similarly, try to avoid discussing any issues with the interpreter that do not require interpretation. This can make the client feel uncomfortable and excluded. If such issues do require discussion, get the interpreter to explain this to the client, or discuss these issues with the interpreter once the client has left (Razban, 2003; Baylav, 2003).

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

7. After the consultation/meeting

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

Schedule 10 minutes with your interpreter after the session to review how you worked together and any other issues relevant to the session (if the interpreter is being paid on a timed basis, this time must be included). This time can be used to:

- Allow time to ask the interpreter their perceptions of the meeting and to inform you of any cultural factors that may be relevant and that you may have missed. This also allows you to check with them about anything you may have noticed, for example from non-verbal communication or expressions.
- Allow you to ask them about any areas that are unclear to you and which their knowledge of the home country or region, or hearing of the account first hand could clarify.
- Ask the interpreter how it was working with you and whether you could usefully change anything in the way you are working (e.g. pace of speaking, length of speaking).

- Do a structured debriefing – as stated above, it may be hard for the interpreter to debrief anywhere else because of their code of confidentiality. There is often no in-house supervision for interpreters. You may wish to provide the interpreter with some contact details in case they need to de-brief at a later stage about your session, remaining mindful of the risks of distress and vicarious traumatisation that the interpreter might face.

8. Written translations

All written translations should be back-translated (i.e. documents being translated from one language into another by one translator and then translated back to the original language by a different translator, the two versions then being compared). This can appear a costly and time-consuming business but can ensure that the translation is clear and states what it is intended to state. There have been many examples of incorrect and sometimes incomprehensible translated versions of English documents, and it is well worth the additional effort of further checks to ensure your message is adequately translated. This may be particularly important when assessment and/or therapy has occurred and is being reported as a legal case

9. Psychometric tests

Clinicians need to be extremely cautious in the use and interpretation of psychometric tests. Firstly they may not have been adapted for the population from which the client originates. Adaptation includes back translation (see point above) measures of equivalence of construct, reliability, validity and norming. See the International Test Commission Guidelines on Test Adaptation (2000) for a full discussion of this.

Neglect of adaptation procedures would mean that the meaning of any results could be severely compromised (Holt Barrett, 2005).

Rahman et al. (2003), writing about a screening questionnaire for mental health, suggest that key informant interviews and focus groups should usefully be undertaken, as questionnaires may incorporate complex conceptual and construct issues. It has also been noted that psychometric measures may have been designed with one group in mind and that the concepts used may not be applicable to another group. For example, in some African cultures it is more common to communicate distress in psychosomatic terms but elevated scores on a psychosomatic index may convey a different meaning to the one that the client might be trying to convey, which would affect the validity of the interpretation of results.

Extreme caution is also needed when considering using psychometric tests with deaf clients (Cromwell, 2005). Few psychometric tests or standardised assessments have been validated on the deaf population.

10. Telephone interpreting

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

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

In the main, however, as stated above, mental health work with its complex and relational setting is better conducted with a face-to face interpreter who, like the psychologist, would use the non-verbal communication of the client as a vital part of what they are able to feedback to the psychologist.

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

11. Other issues to consider

Commissioners need to ensure that there are clear pathways to support for all members of the local community including those who do not speak English. Clients need to know how and where to access services if they require them and this should include language support services (interpreting, advocacy, bilingual link work and translated information).

It has also been shown to be advantageous when interpreters are viewed as part of a mental health team for them to be shown appropriate collegial respect and invited to attend relevant departmental, agency or hospital meetings. Although in practice this rarely happens it is worth considering their inclusion when appropriate, as the benefits of gaining the perspective of an interpreter or bicultural worker can be many. Interpreters can contribute to service provision and delivery and they can gain a better understanding of how organisations function and the context of the work they undertake (Raval & Smith, 2003; Tribe & Morrissey, 2003; Raval, 2005).

Information in the client's own language is important and it is good practice to use translated materials whenever possible, particularly for individuals from larger language groups. A multilingual appointment card (downloadable from www.harpweb.org.uk, see page 3 of these guidelines) or translated appointment letters may help to improve attendance rates.

In addition, written care plans should be available in the client's own language.

When providing written information for deaf people (including care plans) be aware that not all deaf people are comfortable with written English. However, there is no alternative written form for BSL. You may need to be creative and use video or DVD to record a signed version of a care plan.

NHS Direct operates a 24-hour nurse-led advice and health information service[5] providing confidential information and details of local health services including doctors, dentists or late-night-opening pharmacists. NHS Direct can provide interpreters when talking to someone who cannot speak English

12. Recommendations for improvements in the future

It is recommended that each psychologist takes individual responsibility for ensuring they are skilled at working with interpreters. This may have training implications both at a pre-professional and continuing professional development level. Lack of experience or skills should not be used to justify not engaging in therapeutic work via an interpreter. No psychologist should be in a position in which they cannot offer equity of service to all potential referrals.

Further, individual clinicians, as well as the organisations that employ them, have a clinical responsibility towards the interpreters that they employ. In this way, opportunities for debriefing must be offered whether by individual clinicians or through supervision groups as appropriate. It is not good practice to leave interpreters without support for their work with mental health clients.

Each organisation or NHS Trust could benefit from developing its own clinical strategy on language support to consider the ways in which interpreting, translation, advocacy and the work of bilingual staff is integrated into the activities of the organisation overall. This should be viewed as an essential piece of work feeding into the overall race equality policies.

An established career structure for interpreters which acknowledges the important contribution that they make would help to ensure that they are adequately recognised and remunerated for the work which they do at the individual and organisational level.

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[5] The telephone number for NHS Direct is 0845 4647. They also have a website (English only) http://www.nhsdirect.nhs.uk

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